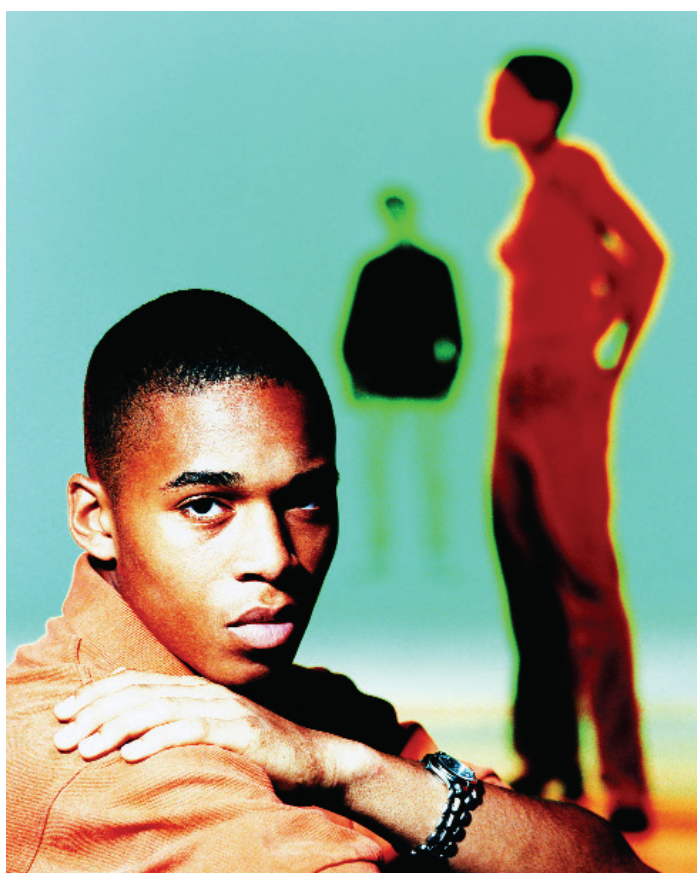


2008 Sexual Health in the South East:

A collaborative report by Health Protection Agency
South East and the South East Public Health Observatory



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Produced by:

Health Protection Agency South East in collaboration with the South East Public Health Observatory

Acknowledgements:

Thank you to colleagues at the Centre for Infections for providing data required for the report and to QResearch for the Primary Care data and their respective EMIS practices who contribute to the QResearch surveillance.

Thank you to Alison Hill for her useful comments when drafting the report.

Target audience:

Commissioners, public health specialists, policy makers and others concerned with tackling sexual health issues in the South East at regional and local level, in the NHS and local government.

Publication date:

June 2008

Further Information:

Further information is available as interactive maps and charts on the SEPHO website www.sepho.org.uk

Local information on STIs is available for NHS organisations through quarterly Local Sexual Health Profiles produced by the South East regional office of the HPA. To be added to the distribution list to receive the profiles please contact Sandra.Johnson@hpa.org.uk

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1. Executive summary and recommendations

Surveillance of sexually transmitted infections (STIs) and HIV is undertaken by the Health Protection Agency (HPA), but is usually presented in isolation from the variety of public health indicators which can help interpret these data. Deficits in surveillance data on sexually transmitted infections diagnosed and managed in primary care can present difficulties in the commissioning of services at local level.

In this report, we attempt to bring together a range of routine data, and newly analysed data including estimates from primary care datasets, which we anticipate will assist public health professionals and commissioners in needs assessment and in the planning of services. The data presented here supplement and contextualise the routine surveillance data published by the Health Protection Agency, in its annual reports and in the quarterly Local Sexual Health Profiles provided to the region's NHS community.

In commissioning services and health promotion activity, we recommend that commissioners and public health specialists should incorporate the full range of data discussed here in needs assessments, service reviews, and performance monitoring, with the support of Regional HPA staff and of the South East Public Health Observatory.

We also recommend that commissioners and public health specialists incorporate analyses of local laboratory data on primary care testing and diagnosis of STIs and HIV, in the development and evaluation of primary care based Enhanced Services in sexual health. Regional HPA staff can assist in their interpretation.

2. Foreword

Sexual health is a major public health problem, which has been recognised in recent years in several policy initiatives¹⁻³. The promotion of good sexual health in a population requires that public health professionals, health care planners and policymakers keep in mind the connection between the different elements of sexual health. Patterns of reproduction, of infection, of contraceptive use and of abortion are linked with each other, and have major implications for the long term health of the population through the long term clinical and social impacts of poor sexual health.

The HPA is responsible for supporting the control of sexually transmitted infections through the provision of surveillance information, which informs and supports control activities undertaken by the NHS. The HPA supports sexual health improvement at local, regional and national levels in England, through a range of activities including the management of the National Chlamydia Screening Programme and epidemiological advice and support for outbreaks and other incidents.

In 2006, HPA South East, South East Public Health Observatory (SEPHO) and the Government Office of the South East jointly produced a report which for the first time described the breadth of sexual health indicators across the South East⁴. Its approach of bringing together public health data across sexual health was welcomed by public health professionals in the region.

This year's report provides an update on key sexual health information across the South East, and includes information from several data sources which are not yet routinely provided in national surveillance reports. We hope that it will be useful for all those who are charged with the planning of sexual health services in our region. It complements a variety of data sources available at national level through the HPA⁵, and also the quarterly sexual health local profiles which are provided by the HPA to the local NHS communities.

Any comments and suggestions for our next annual report are welcomed, and should be sent to by e-mail to Sandra.Johnson@hpa.org.uk

3. The state of sexual health in the South East

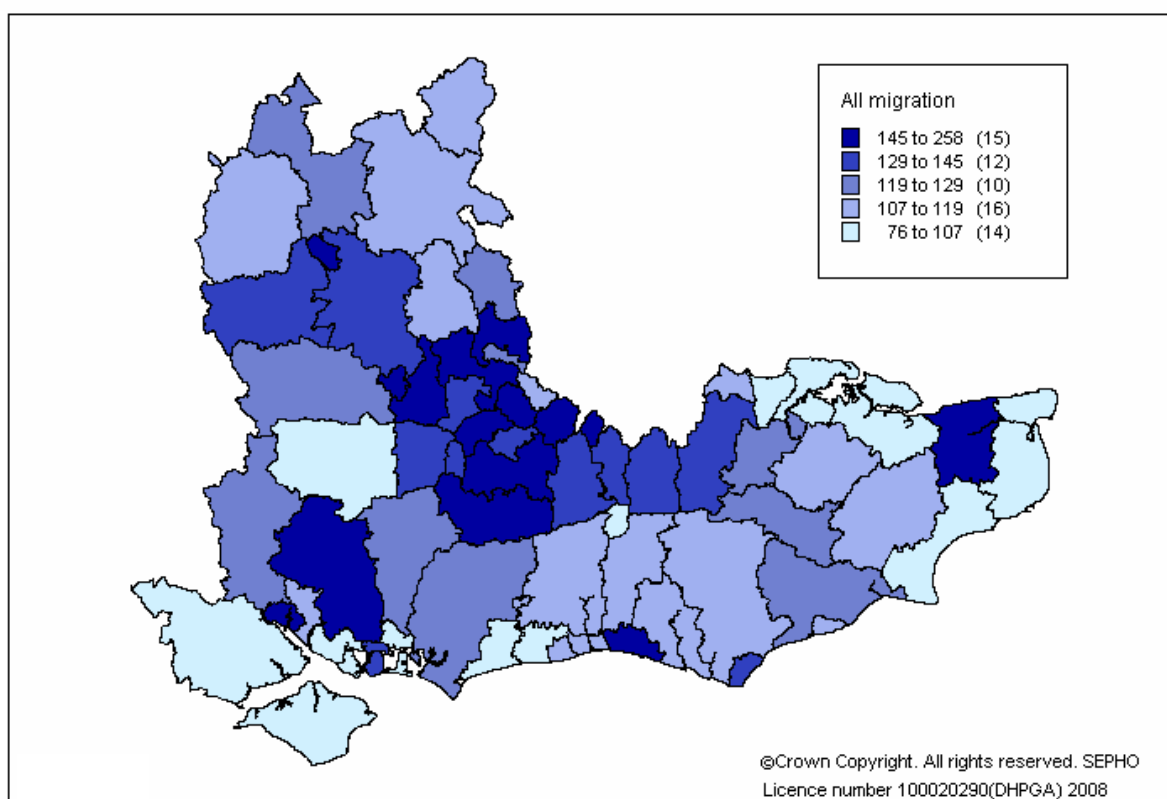
3.1. The changing population of the South East – migration and sexual health.

The South East experiences substantial rates of migration, which includes both movement within the UK and from outside our borders. Figures 1 and 2 summarise All Migration and International Migration into the South East per 1,000 population, from mid 2001 to mid 2006 from data obtained through the Office of National Statistics.

Higher rates of migration are generally seen in urban areas; in particular those which host higher education institutions and those in which there have been historic labour shortages.

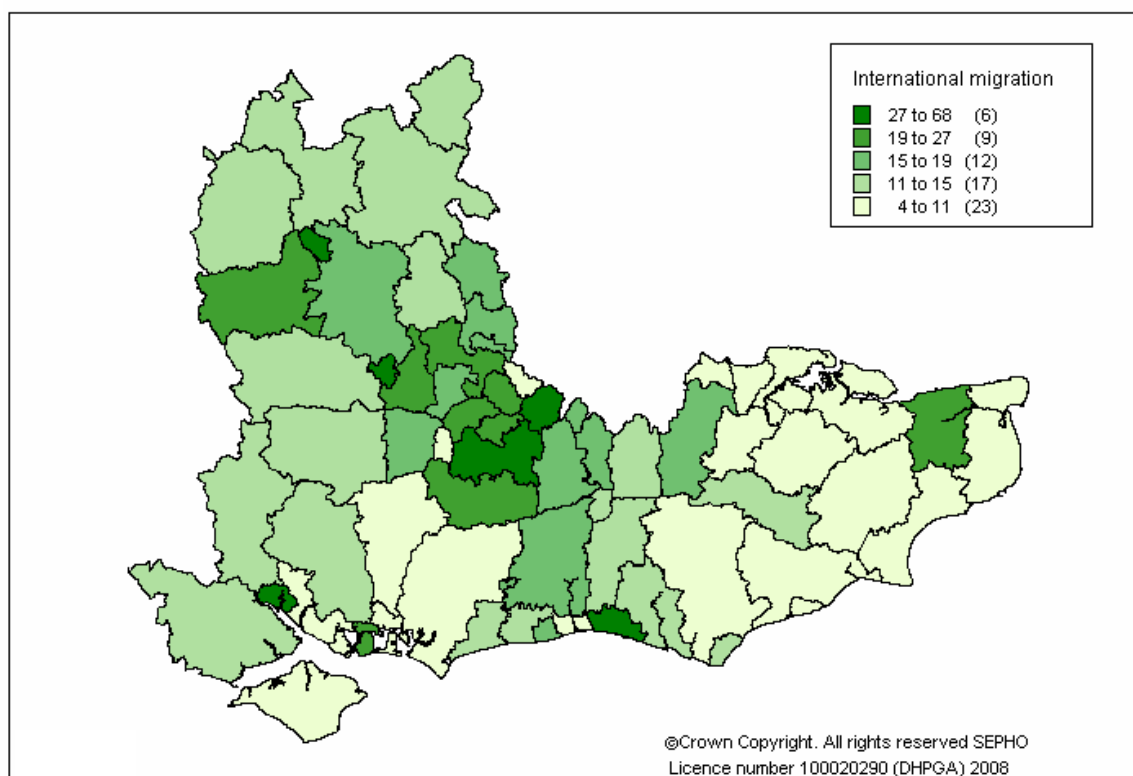
Migration, whether national or international, is associated with an increase in sexual risk at population level, as previous relationships are left behind and new ones formed. Those who have migrated, whether for education, work, or in refuge from conflict, are particularly in need of easily accessible services for contraception and STIs. Health promotion materials need to be targeted to these groups, and while this can be easy for student populations, other newly migrating populations may require novel materials and approaches to be developed.

Figure 1:
Volume of all
migration per
1,000
population Mid-
2001 to Mid-
2006^{1,2}
Source: Office of
National Statistics



1. Volume of migration per 1,000 population is calculated as $(\text{in migration} + \text{out migration}) / \text{population} \times 1000$ (for all migration). 2. Internal migration into and out of higher level areas is not the sum of numbers moving into or out of component lower level areas, as some migrants move between lower level areas as well.

Figure 2:
Volume of
international
migration per
1,000
population Mid-
2001 to Mid-
2006^{1,2}
Source: Office of
National Statistics



1. Volume of migration per 1,000 population is calculated as $(\text{in migration} + \text{out migration}) / \text{population} \times 1000$ (for international migration). 2. Internal migration into and out of higher level areas is not the sum of numbers moving into or out of component lower level areas, as some migrants move between lower level areas as well.

3.2. Sexual Behaviour

Sexual behaviour is an important determinant of sexual health, since people involved in risky sexual behaviour are more likely to acquire sexually transmitted diseases.

Men who have sex with men experience a disproportionate burden of sexual ill health; particularly gonorrhoea and syphilis. Obtaining accurate information about this population is difficult, but one approach is to examine the proportion of adults living in same sex partnerships, using information from the 2001 census. Figure 3 shows the percentage of all people aged 16 and over living in a household in a same sex couple for local authorities in the South East. It shows that Brighton and Hove has a particularly high proportion of such households compared with the rest of the South East, but there is less dramatic variation between other PCTs.

3.3. Conceptions, births and abortions

Fertility Rate

Patterns of sexual health are strongly linked to “fertility” – the reproductive behaviour of women at population level. This is measured in a variety of ways, allowing us to see how reproduction varies across the South East.

The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15-44, and measures the “intensity” of reproduction in a population. The Total Fertility Rate (TFR) is the average number of children that would be born per woman if women experienced the age-specific fertility rates throughout their childbearing years. The GFR is lower in the South East than in England (Figure 4), with the highest rate being in Slough which also has the highest TFR as shown in Figure 5. To assess whether or not fertility rates are high enough to sustain the population, the replacement fertility

has to be considered. Replacement fertility is the total fertility rate at which women would have only enough children to replace themselves and their partner, so in theory the replacement rate would be exactly 2, but in practice it is affected by mortality, especially childhood mortality. The replacement fertility rate is roughly 2.1 births per woman for most industrialized countries but ranges from 2.5 to 3.3 in developing countries because of higher mortality rates, therefore any area which has a TFR of less than 2.1 is looking at a decline in population.

Figure 3:
Percentage of
all people aged
16 and over
living in a
household in a
same sex
couple by Local
Authority in the
South East
region
Source: *Census*
2001

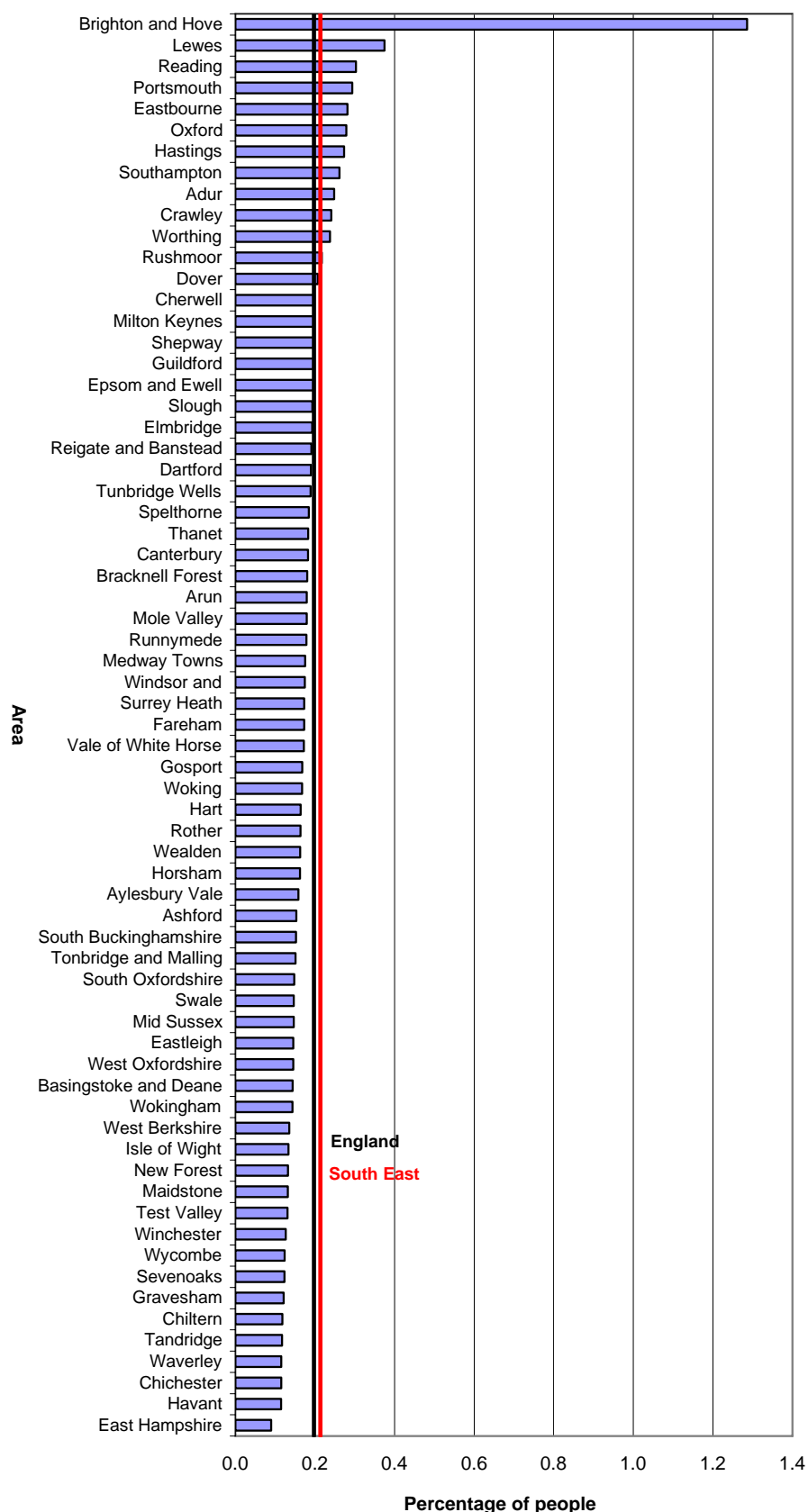


Figure 4:
Number of live
births per 1,000
women aged 15-
44 (General
Fertility Rate) by
Local Authority in
the South East,
2006
Source: Office for
National Statistics

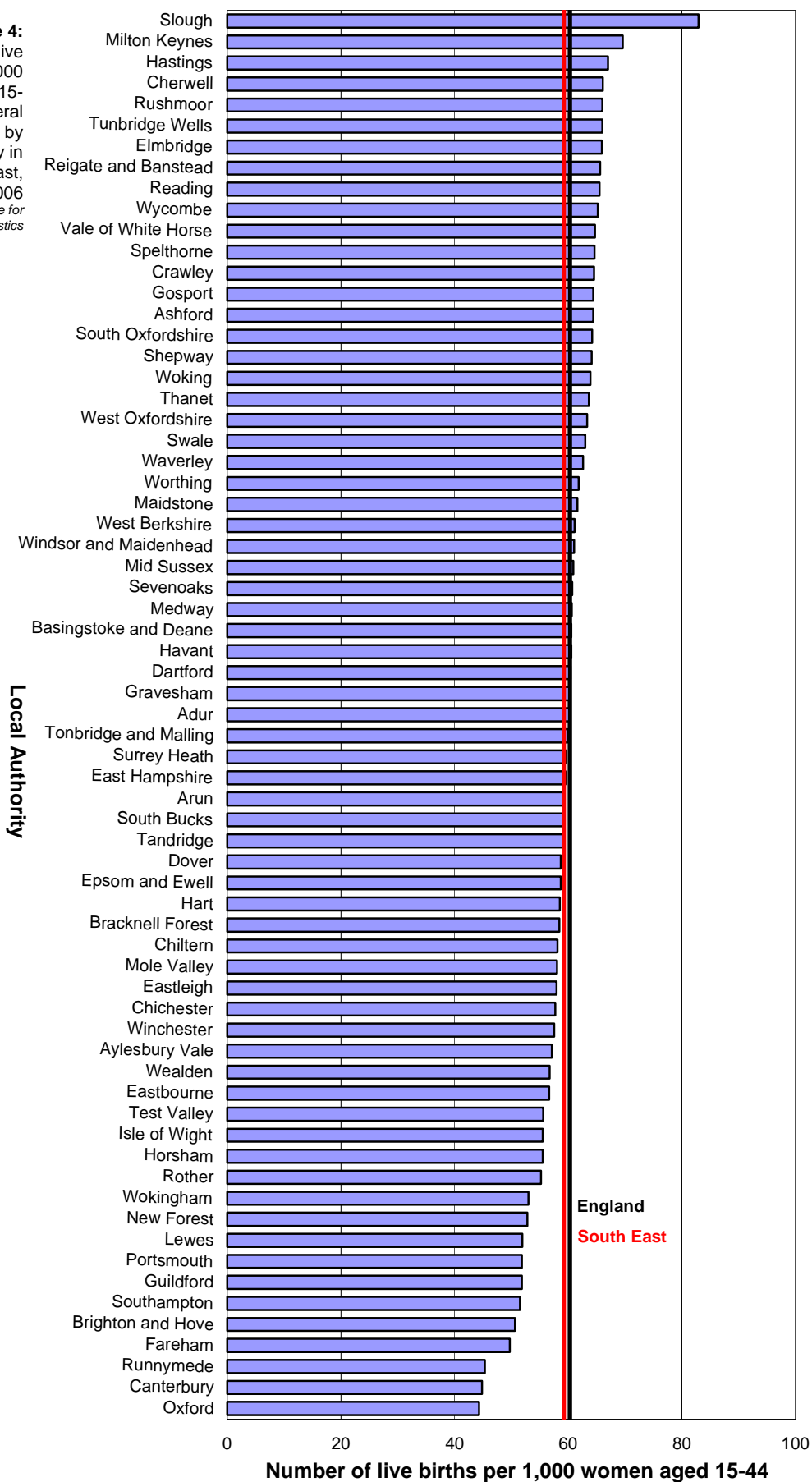
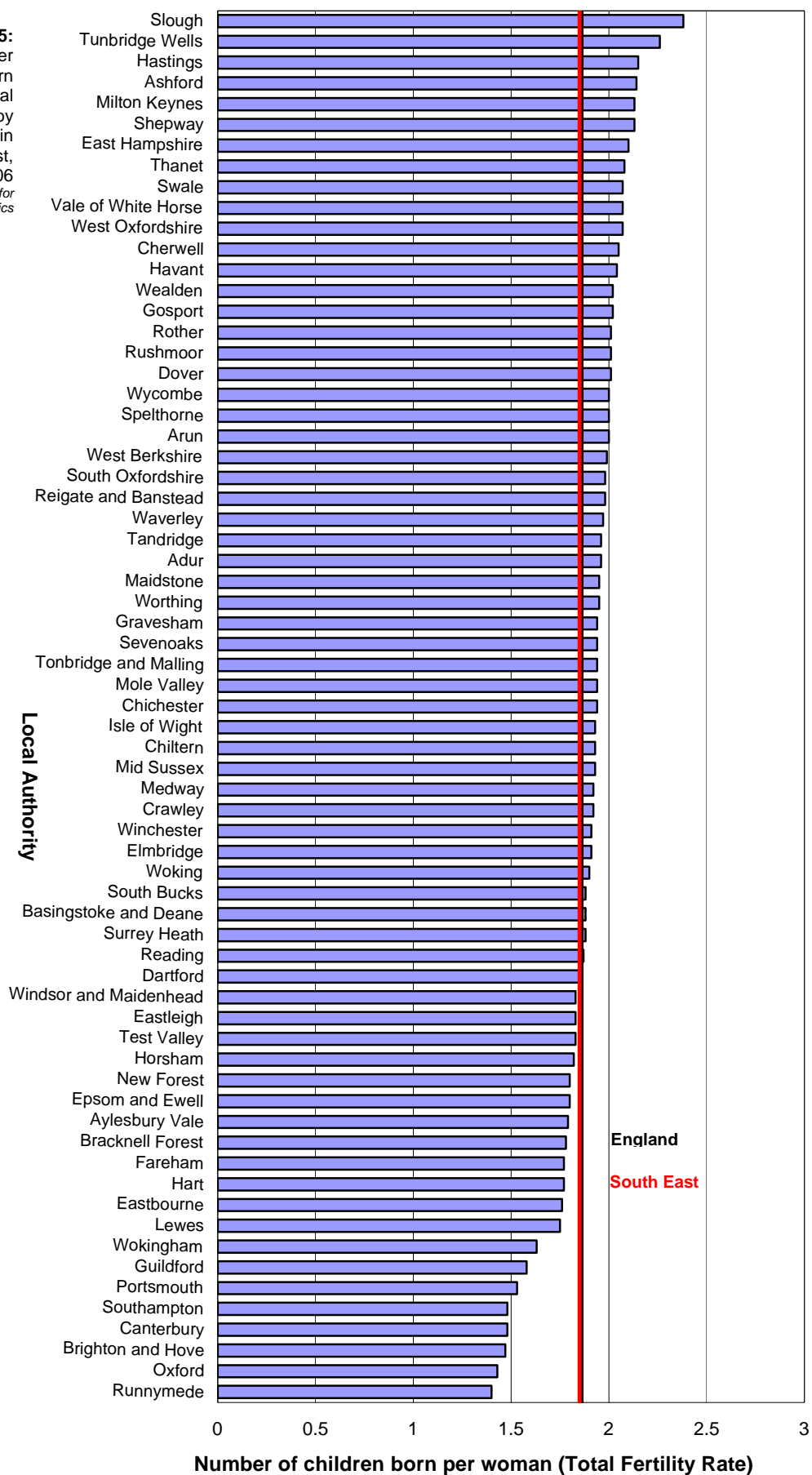


Figure 5:
Average number
of children born
per woman (Total
Fertility Rate) by
Local Authority in
the South East,
2006

Source: Office for
National Statistics



Teenage Pregnancy

Trend data on conceptions among women aged 15-17 by region and nationally are shown in Figure 6 and 7. The South East has a lower rate of conceptions than England but a higher percentage of abortions. Figure 8 shows rates of conceptions and the percentage leading to abortion by Unitary Authority. The trend observed is the areas that have the highest number of conceptions (Reading, Southampton and Portsmouth) have some of the lowest percentage that lead to abortions whereas Buckinghamshire, Windsor and Maidenhead and Wokingham have the lowest rates of conceptions and some of the highest percentages that lead to abortions. The rate of under 18 conception is inversely correlated with the percentage of pregnancies ending in abortion.

Figure 6:
Rate of under 18 conceptions per 1,000 female population aged 15-17 in England by Government Office Region 1998-2006
Sources: Office for National Statistics and Teenage Pregnancy Unit



Figure 7:
Percentage of under 18 conceptions that led to an abortion in England by Government Office Region 1998-2006
Sources: Office for National Statistics and Teenage Pregnancy Unit

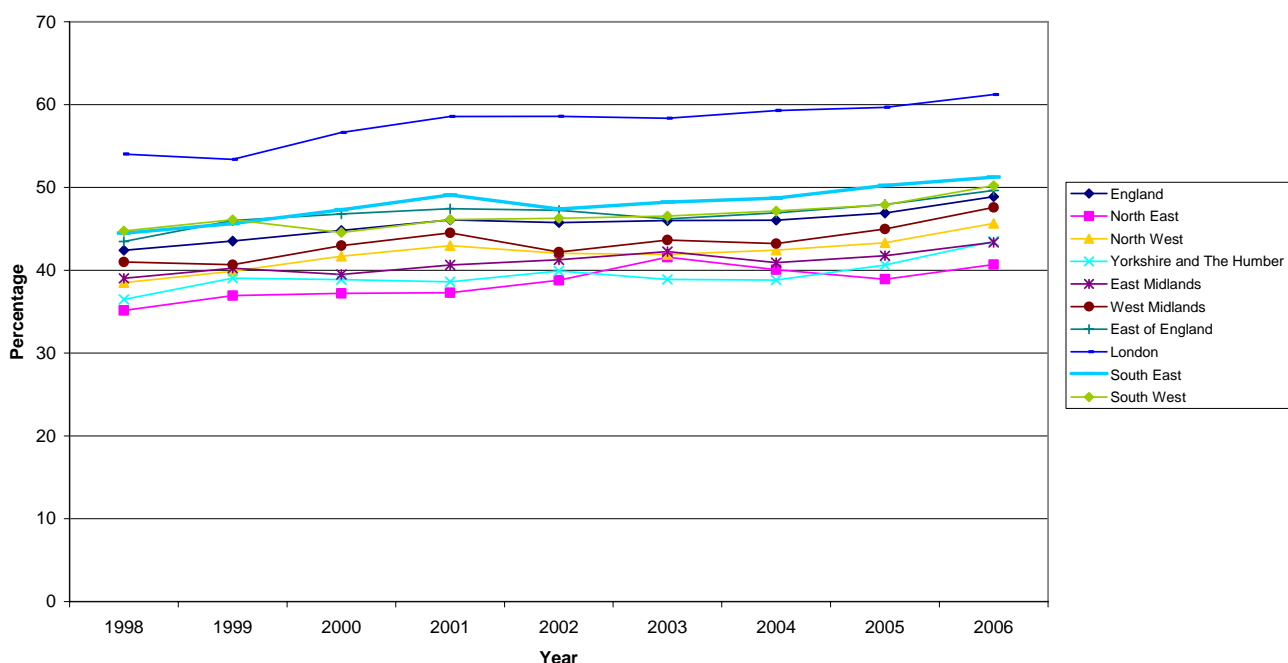
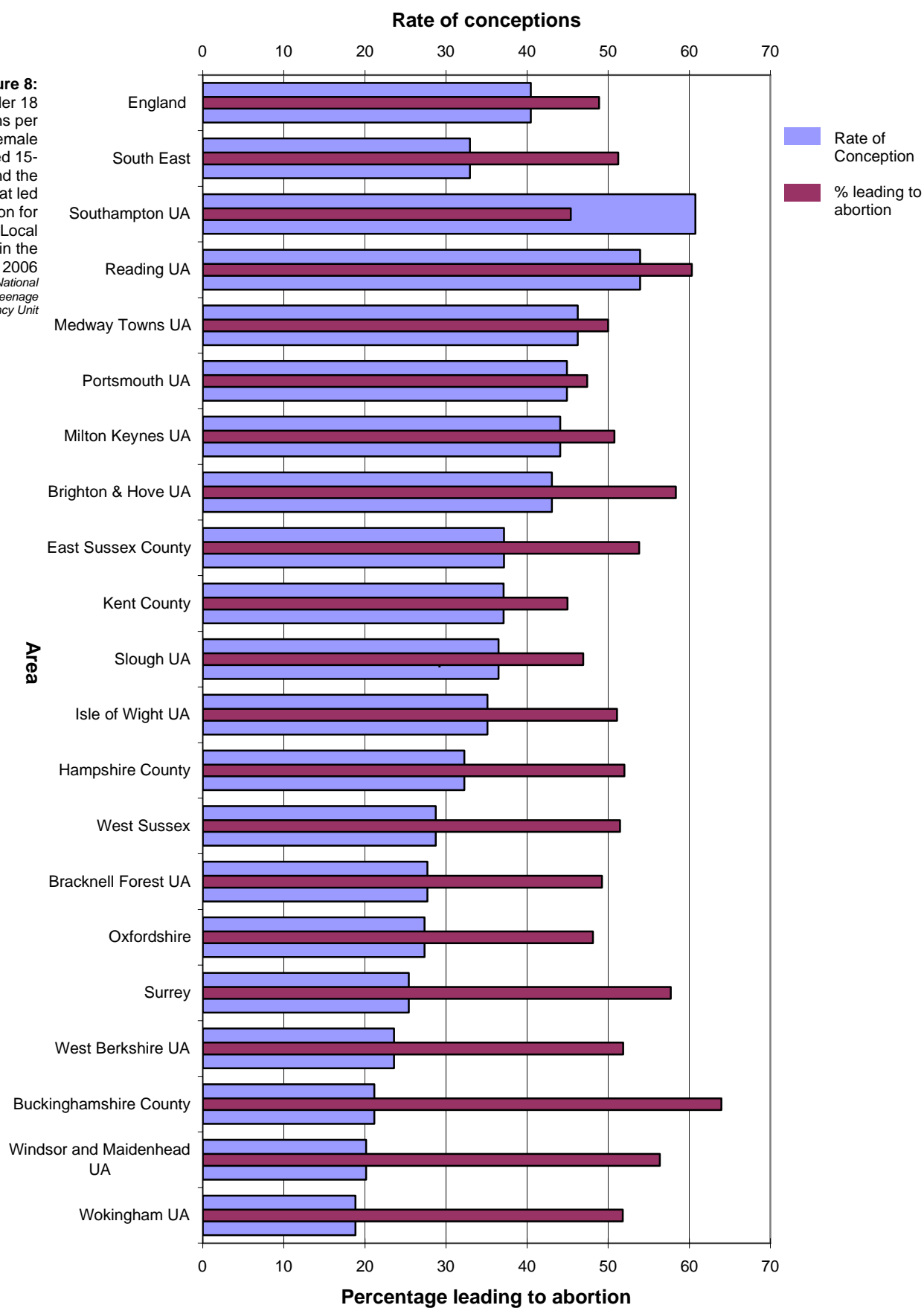


Figure 8:
Rate of under 18
conceptions per
1,000 female
population aged 15-
17 and the
percentage that led
to an abortion for
top-tier Local
Authorities in the
South East 2006
*Sources: Office for National
Statistics and Teenage
Pregnancy Unit*

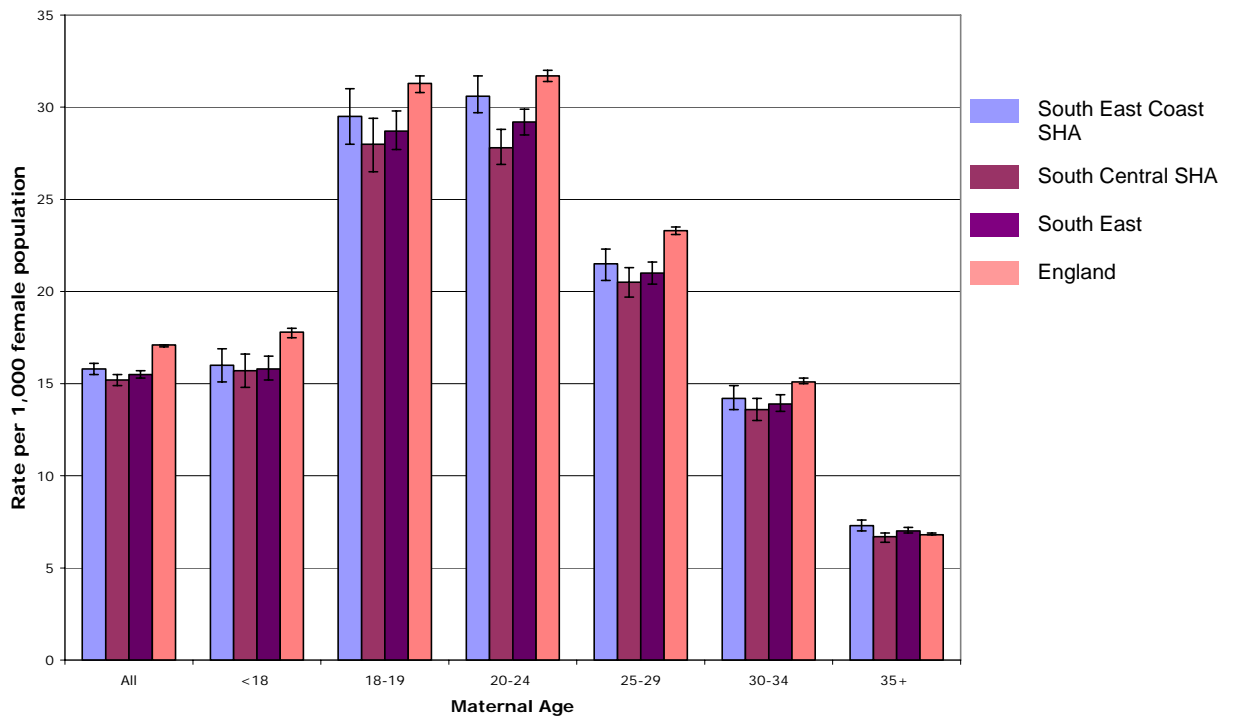


Abortions

Figure 9 illustrates the abortion rate per 1,000 women showing variation by maternal age. Abortion rates are highest among women aged 18-24 both nationally and regionally. The abortion rates in South East Coast and South Central SHA areas are similar apart from women aged 20-24 years in South East Coast SHA who have a higher rate. Overall abortion rates in the South East region and the South East SHAs are significantly lower than in England as a whole.

Figure 9:
Rate of abortion per
1,000 women by
maternal age group;
England, South East
region and Strategic
Health Authorities in
2005

Source: *Compendium of
Clinical and Health
Indicators / Clinical and
Health Outcomes
Knowledge Base. The
Information Centre for
health and social care. ©
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Teenage pregnancy and deprivation

Figures 10 and 11 explore the relationship between pregnancy among females aged under 18 and deprivation. These are shown as scatter graphs where one dot represents one local area. Figure 10 shows that there is a positive relationship between teenage conceptions and the Index of Multiple Deprivation (IMD) while Figure 11 shows that there is a negative association between abortions and IMD. This means that girls aged under 18 from deprived areas are more likely to get pregnant and less likely to terminate that pregnancy.

Figure 10:
Conception rates
among females
aged 15-17 in
district and unitary
authorities in the
South East 2003-
2005 and Index of
Multiple
Deprivation
Scores 2007
*Source: Teenage
Pregnancy Unit, Index of
Multiple Deprivation
2007*

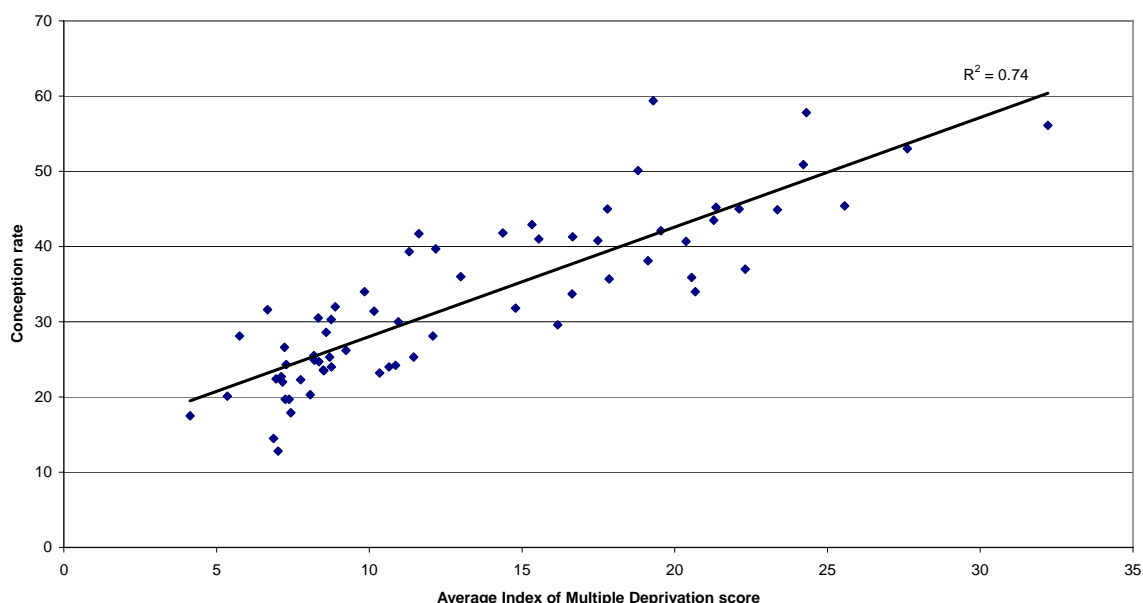
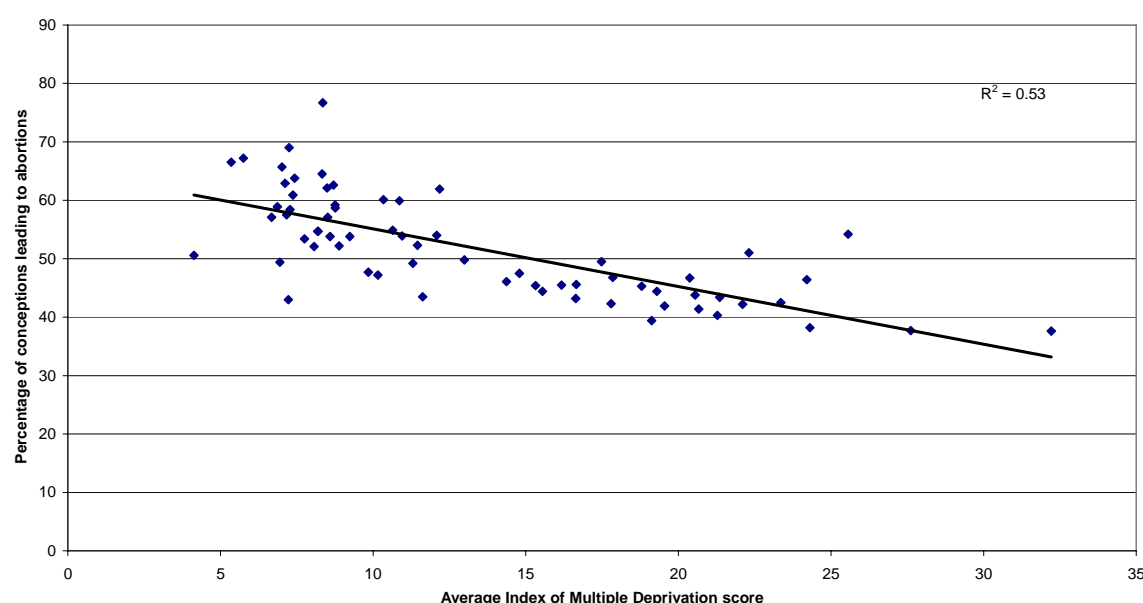


Figure 11:
Percentage of
conceptions
leading to an
abortion among
females aged 15-
17 in district and
unitary authorities
in the South East
2003-2005 and
Index of Multiple
Deprivation
Scores 2007
*Source: Teenage
Pregnancy Unit, Index of
Multiple Deprivation
2007*



3.4. HIV and sexually transmitted infections

A number of surveillance systems in England assess levels of HIV and STIs⁵. Reports of new diagnoses of HIV are made by microbiologists and clinicians upon making the diagnosis. Data on the number of individuals currently accessing care for HIV are also collected by the SOPHID surveillance system. This includes area of residence at PCT level, along with other epidemiological data, including probable source of infection and disease stage at diagnosis.

Data on other sexually transmitted infections (STIs) are primarily collected through surveillance of genitourinary medicine (GUM) clinics. Historically there has been a lack of data from the primary care setting, but research into the use of electronic patient records in primary care is now improving this situation^{6;7}. These data have demonstrated that the numbers of STIs diagnosed and treated in the primary care setting have increased in recent years. As described below recent data collected from primary care through a sentinel surveillance system (Qresearch) have been analysed.

HIV in the South East

Recent changes in health boundaries, namely the increased size of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs), have posed a problem with displaying data at a level that still contains sufficient information. Due to this problem, we have chosen to display HIV data to old SHA boundaries, which are coterminous with the geographies covered by HPA Health Protection Units (HPUs).

Figure 12 shows rates of new HIV diagnoses by HPU in the South East, in the region as a whole and in England, between 1996 to 2006. Thames Valley and Surrey and Sussex follow the national trend closely whereas rates in Hampshire and the Isle of Wight and Kent are approximately half those observed for England. Rates in all areas have increased from 1999 and the rates observed in 2006 are expected to increase as further reports are received.

Figure 13 and 14 show the prevalence of people living with HIV per 100,000 by PCT within the South East for 2002 and 2006. As expected Brighton PCT has the highest numbers overall both in 2002 and 2006. Numbers have increased in all other PCTs (data not shown).

Figure 12:
Rate of new HIV
diagnoses by
HPU, South East
region and
England per year
between 1996 to
2006
Source: HPA

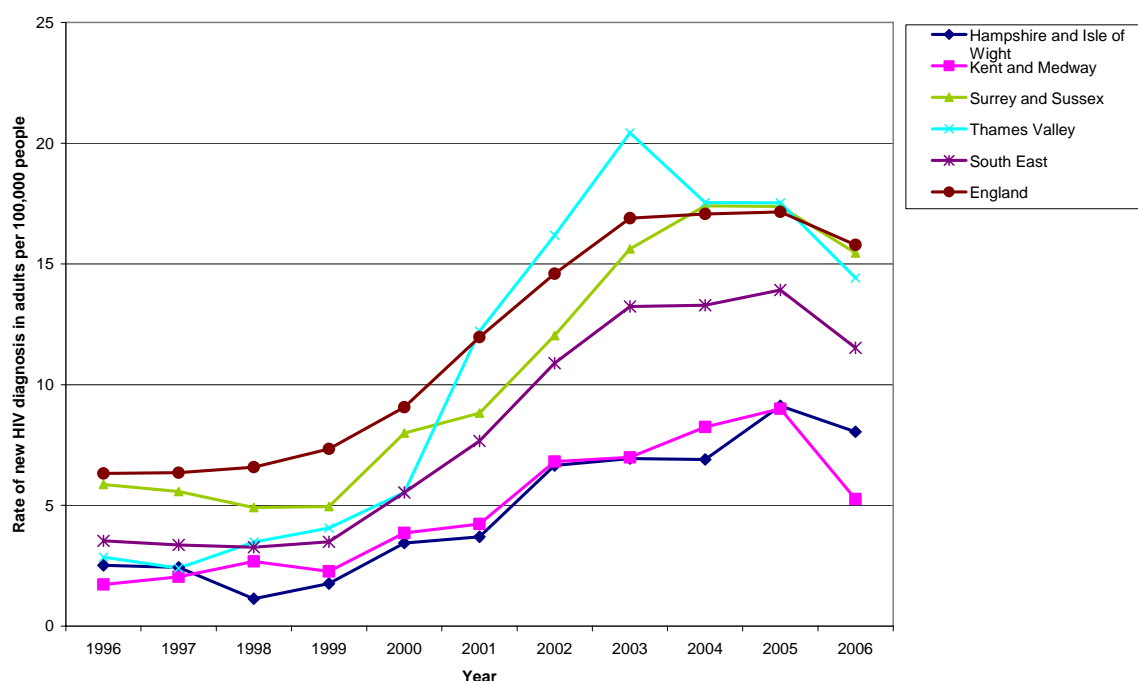


Figure 13:
Prevalence of
people living with
HIV within the
South East per
100,000
population by PCT
in 2002
Source: HPA

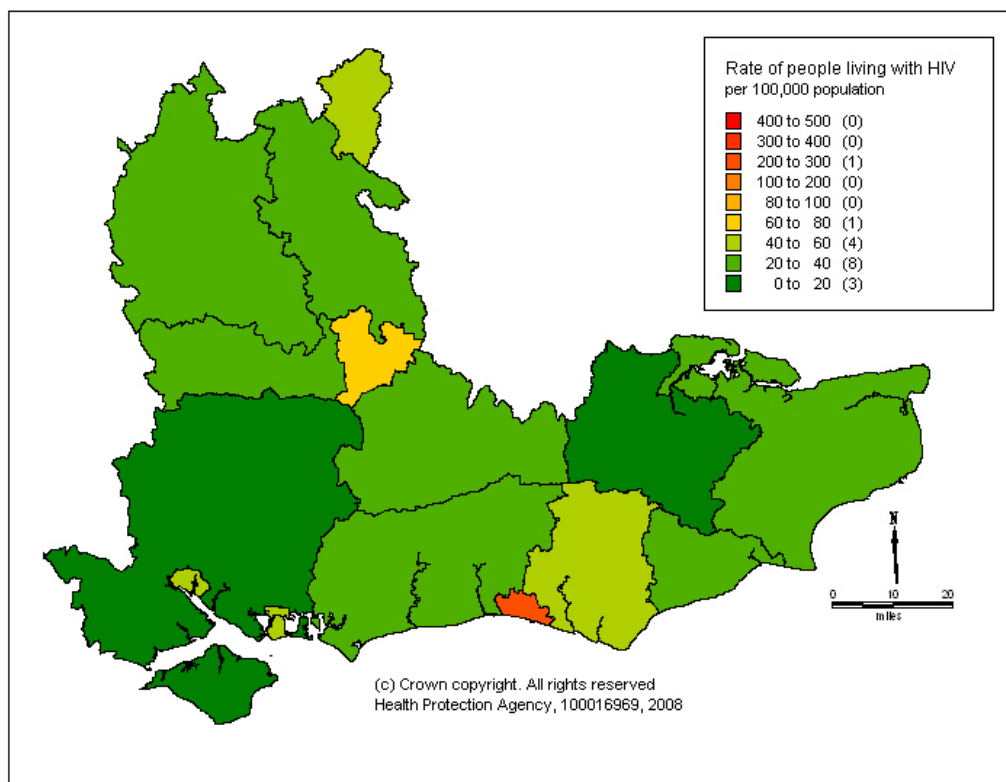
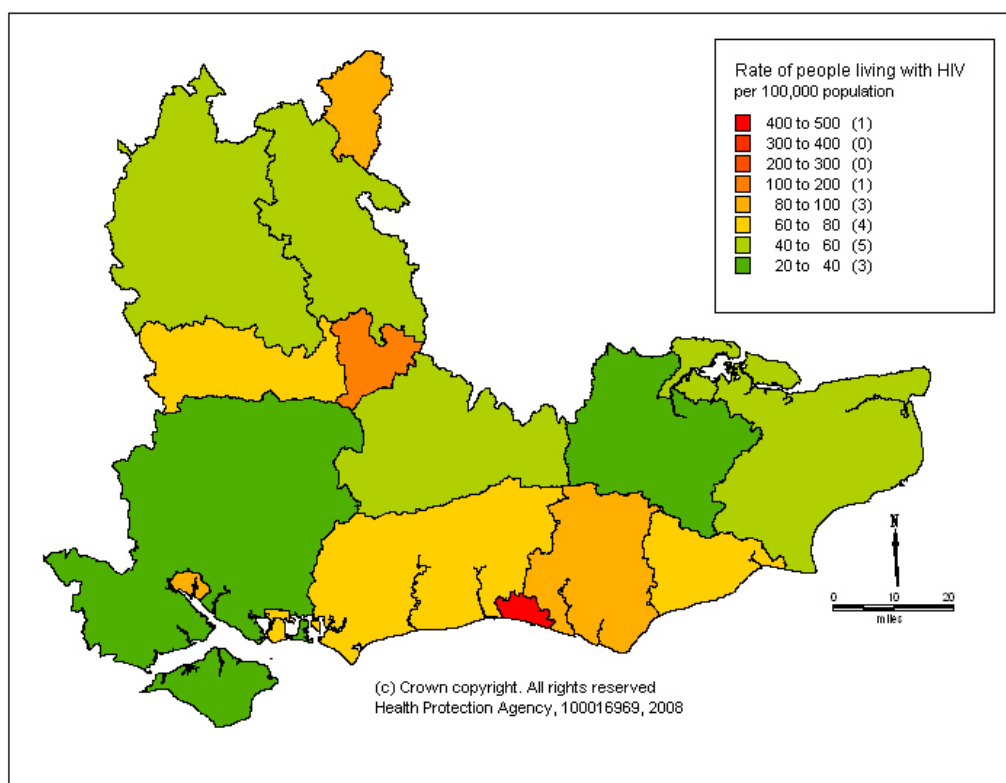


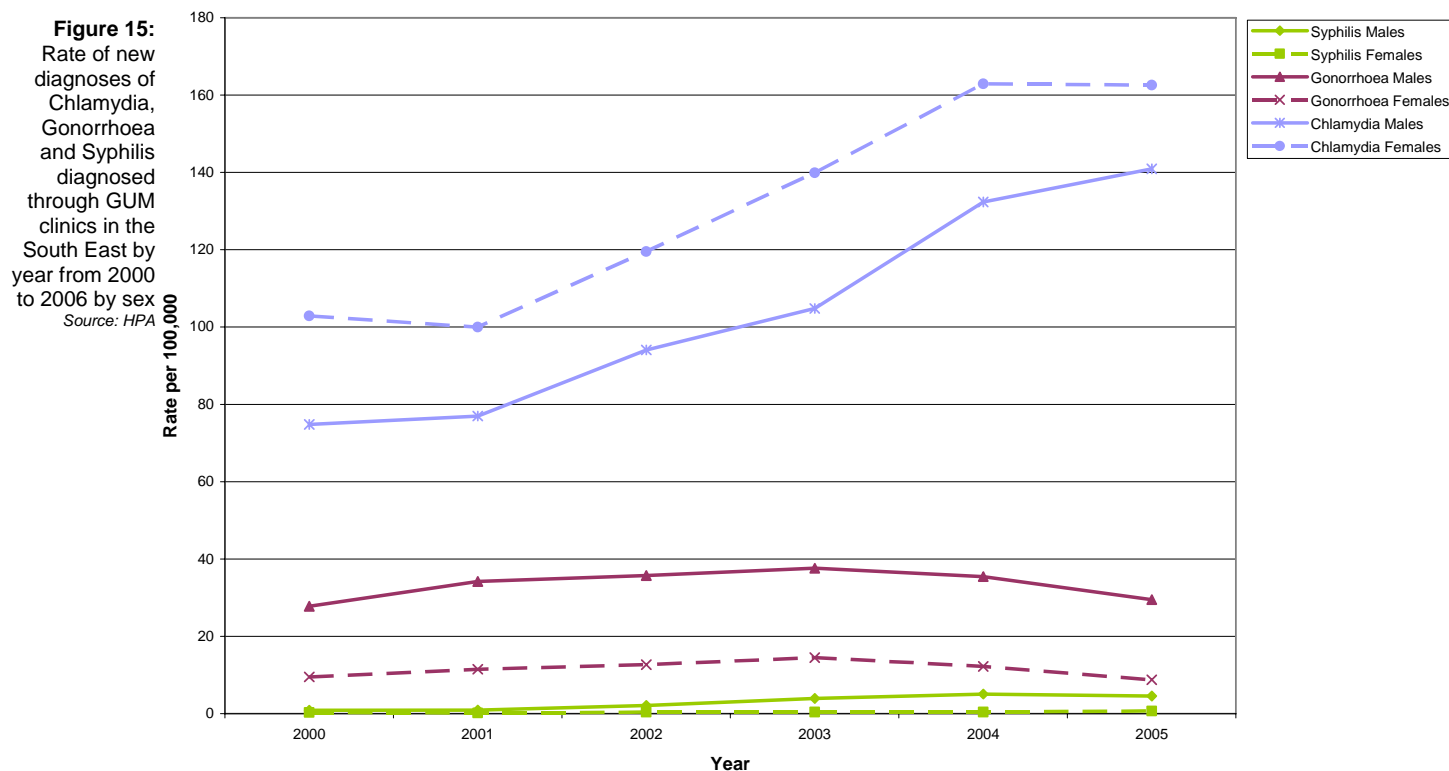
Figure 14:
Prevalence of
people living with
HIV within the
South East per
100,000
population by PCT
in 2006
Source: HPA



Sexually transmitted diseases in the South East

STIs over time

Figure 15 shows rates of Chlamydia, Gonorrhoea and Syphilis diagnosed in GUM clinics in the South East from 2000 to 2006 by sex.



Overview of the comparison between primary care and GUM data

Figures 16 to 24 compare rates, in respect to sex and age groups, of STIs diagnosed both in the GUM setting (KC60) and in general practice. General practice data is estimated in an analysis of primary care data on a sample of practices in the South East by the “QResearch” group at Nottingham University in collaboration with the HPA. General practice data come from practices using EMIS™ software, which contribute and also assist in supporting and developing QResearch surveillance. It should be noted that STI testing rates in primary care are highly variable⁸, and there is no reason to assume that contributing practices are typical or atypical.

These data show that while the majority of diagnoses of STI are made in the GUM clinic setting, this varies by disease. A small proportion of Chlamydia diagnosed in primary care is in men – this relates to a known deficit in the testing of men in the primary care setting⁸. While genital warts and Chlamydia are diagnosed in substantial numbers in primary care, only an extremely small number of diagnoses of gonorrhoea are made in the primary care setting. This is likely to reflect the, on average, much higher numbers of sexual partners of patients with gonorrhoea (and also for syphilis not shown here)⁹. The majority of patients with gonorrhoea may be appropriately identifying their need to access specialist GUM services rather than primary care, where HIV testing and testing for other STIs is less commonly undertaken¹⁰.

Chlamydia

Chlamydia diagnosis rates are shown in figures 16 and 17. Females in the 16-19 age group have the highest rates of diagnosis in both settings, with GUM diagnoses over 1000 per 100,000 population (1%) in GUM and over 200 per 100,000 in general practice (0.2%).

Diagnosis in females then decreases with increasing age. Diagnoses in males are highest in the GUM setting for the 20-24 year olds where rates are over 800 per 100,000 population (0.8%). There are considerably lower diagnoses of Chlamydia in males compared to females through general practice.

The National Chlamydia Screening Programme (NCSP) is now beginning to publish local data through the local sexual health profiles, and HPA South East is currently undertaking analysis of data at regional level which will describe emerging patterns of inequality in coverage, and enable targeted action.

Figure 16:
Rate of Chlamydia
diagnosis in GUM
clinics in 2006 per
100,000 by age
group and sex in
the South East
region
Source: HPA

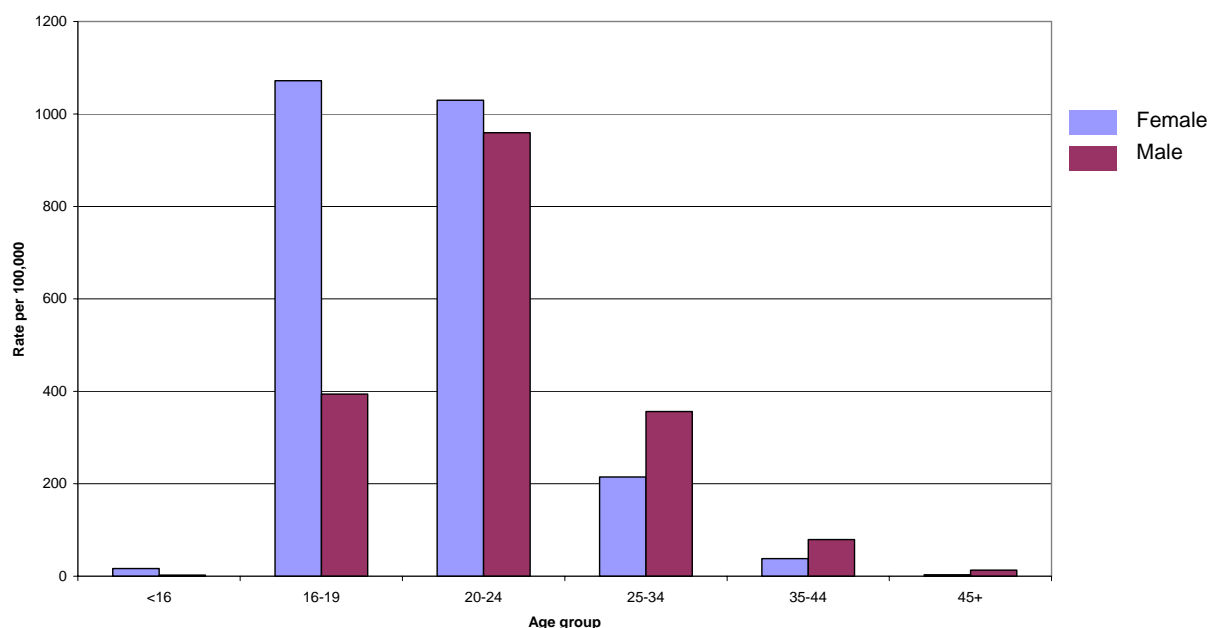
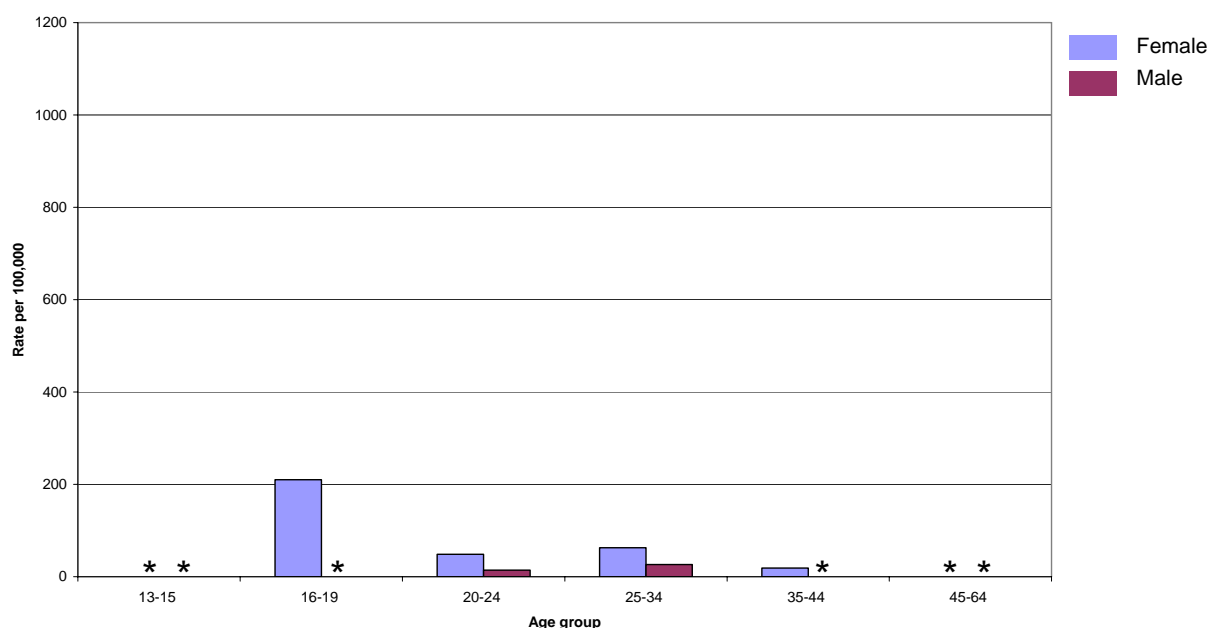


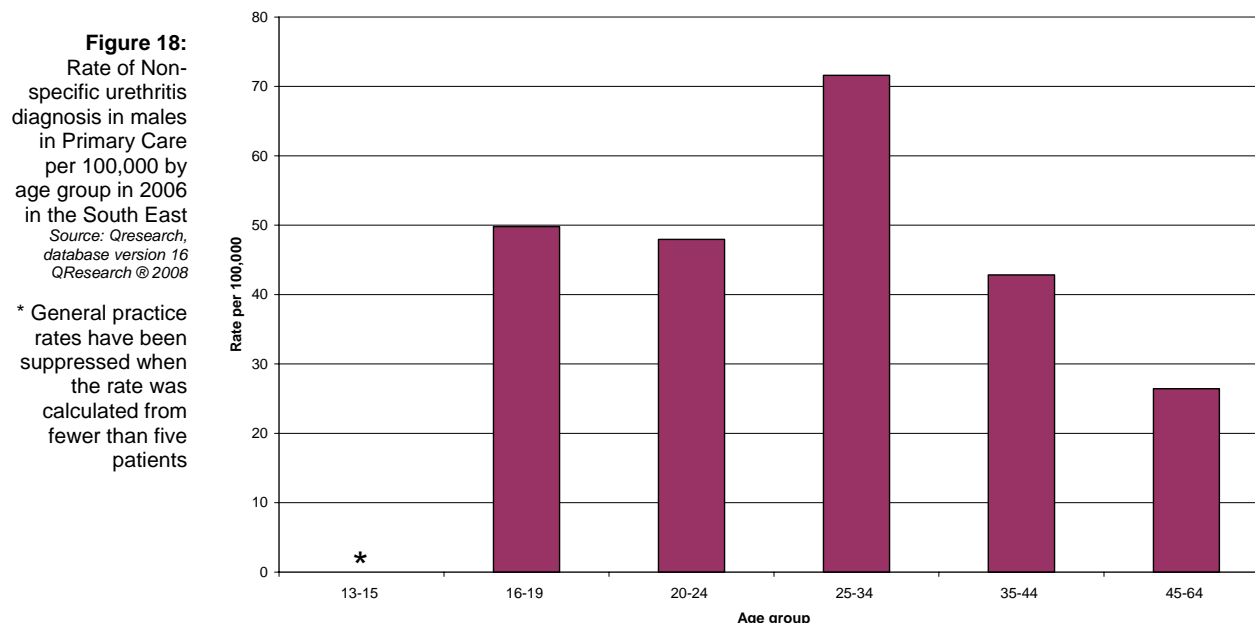
Figure 17:
Rate of Chlamydia
diagnosis in
Primary Care per
100,000 by age
group and sex in
2006 in the South
East
*Source: Qresearch,
database version 16
QResearch © 2008*

* General practice
rates have been
suppressed when
the rate was
calculated from
fewer than five
patients



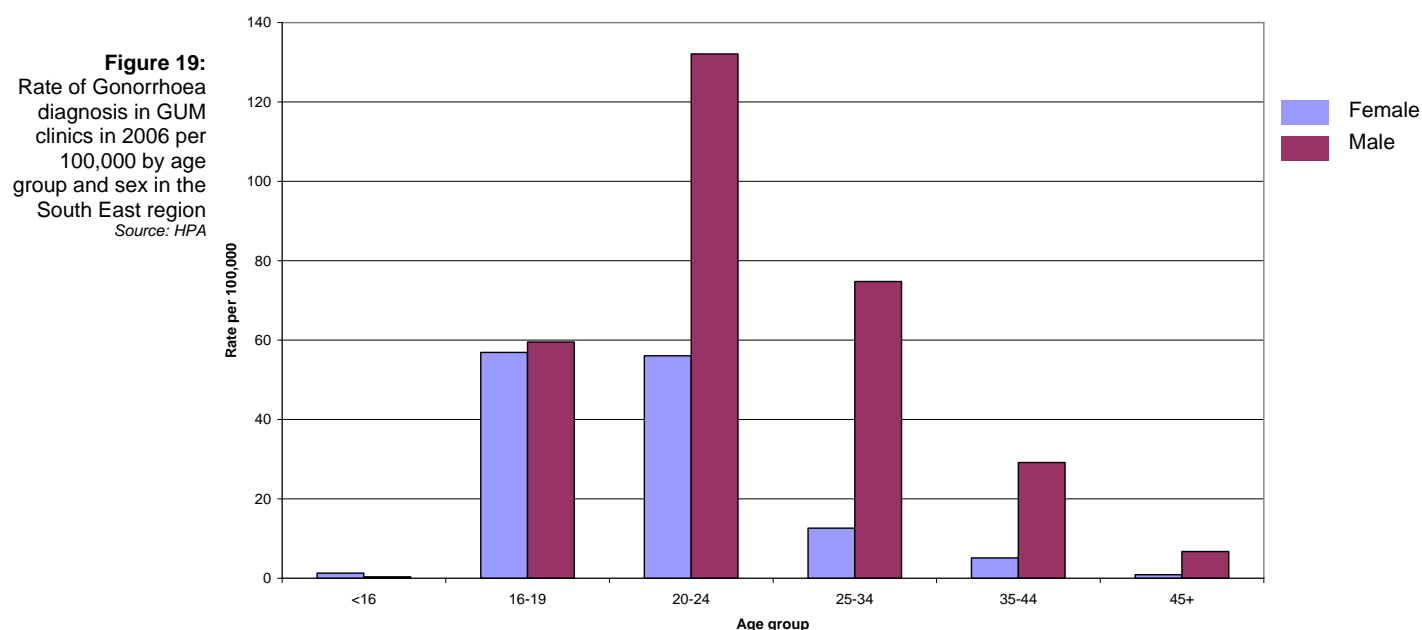
Non-specific urethritis

Non-specific urethritis (NSU) or urethral discharge rates from general practice are shown in figure 18. NSU is not collected by age group for GUM so has not been shown. Highest rates of diagnoses are in the 25-34 year age group. A previous study have suggested that often in general practice men with urethral discharge are treated syndromically (without a microbiological diagnosis) and are treated with antibiotics appropriate for NSU⁶. This may result in underdiagnosis of chlamydia among men presenting to the primary care setting with symptoms with a diagnosis of NSU given to a higher proportion than in GUM clinics.



Gonorrhoea

Gonorrhoea diagnosis rates are shown in figure 19. The data reflect the concentration of gonorrhoea in men who have sex with men (MSM), which is the case at national and regional level⁵. Diagnoses of Gonorrhoea vary by sex with males having considerably increased diagnoses in all ages over 16-19 years old, with a peak of over 130 per 100,000 (0.13%) in the 20-24 year olds. Diagnoses within general practice are considerably lower and have not been shown.



Genital Warts

Genital warts diagnosis rates are shown in figures 20 and 21. Diagnoses in females are over 700 per 100,000 (0.7%) in females aged between 16-19, and in males and females aged 20-24 in GUM. The sex distribution of warts diagnoses in GUM is similar to that observed in general practice.

Figure 20:
Rate of Genital
Warts diagnosis in
GUM clinics in
2006 per 100,000
by age group and
sex
Source: HPA

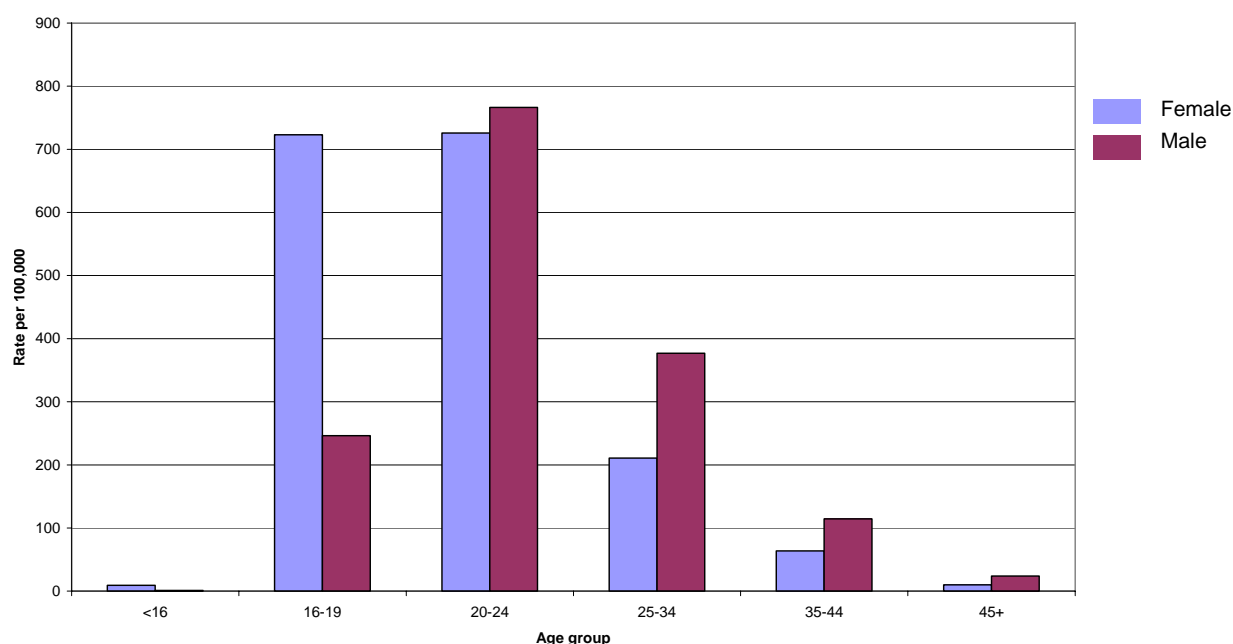
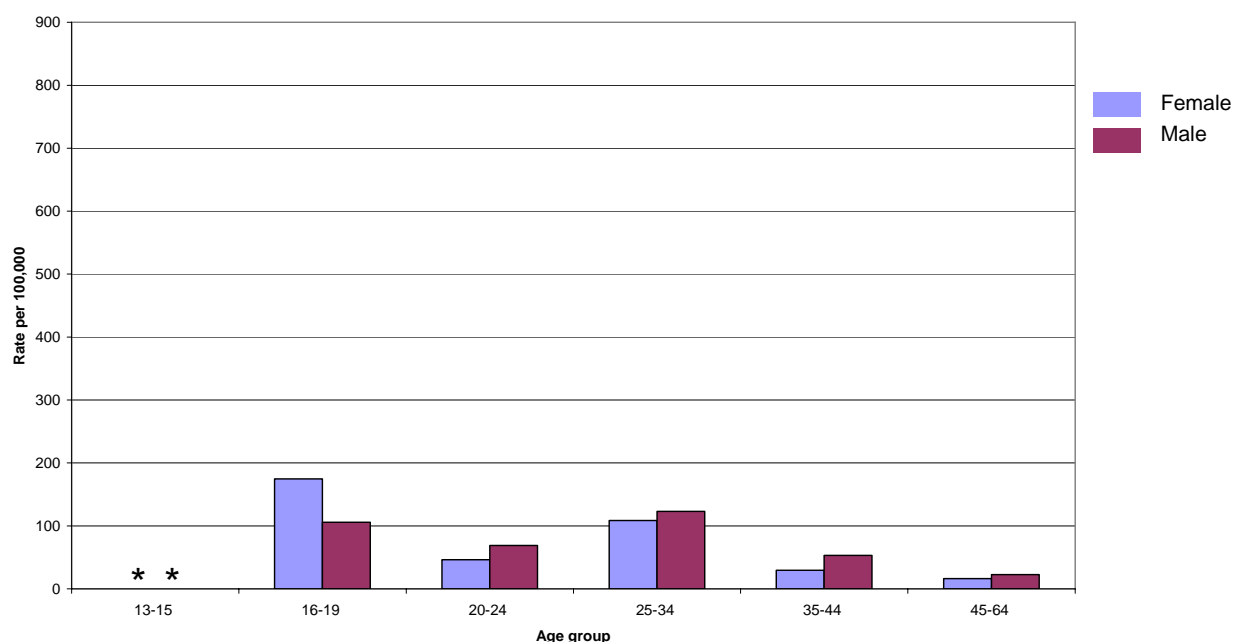


Figure 21:
Rate of Genital
Warts diagnosis in
Primary Care per
100,000 by age
group and sex in
2006 in the South
East
*Source: Qresearch,
database version 16
QResearch © 2008*

* General practice
rates have been
suppressed when
the rate was
calculated from
fewer than five
patients



Genital Herpes

Herpes diagnoses rates are shown in figures 22 and 23. Rates are also considerably higher in females aged 16-19 and 20-24 in the GUM data but for the older age groups rates are comparable between sexes. Although overall rates are lower in general practice they are considerably higher for females compared to males in general practice especially the 16-19 and 25-34 year age groups.

Figure 22:
Rate of Genital
Herpes
diagnosis in
GUM clinics in
2006 per
100,000 by age
group and sex
Source: HPA

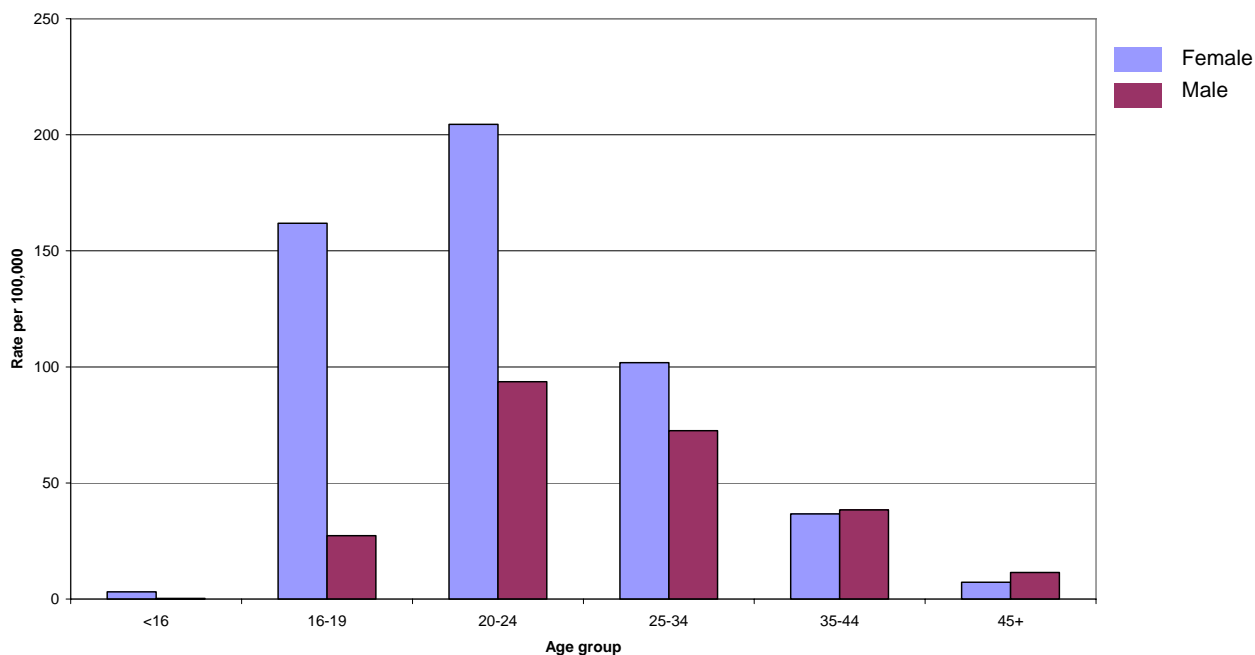
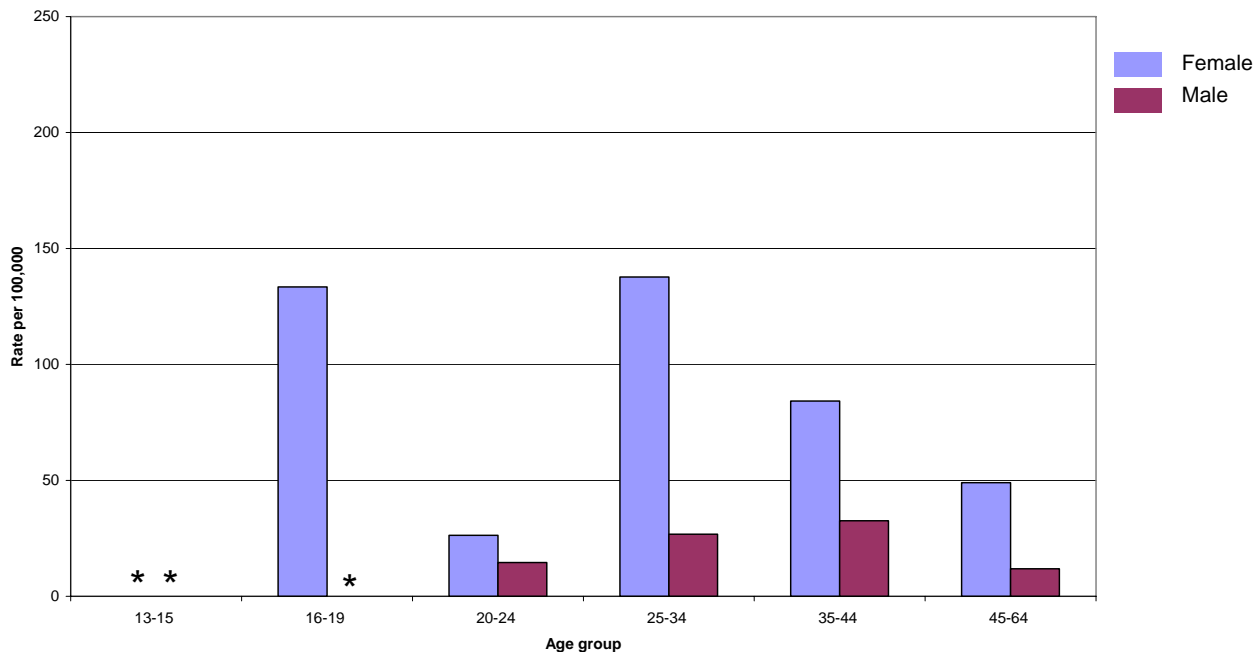


Figure 23:
Rate of Genital
Herpes
diagnosis in
Primary Care
per 100,000 by
age group and
sex in 2006 in
the South East
*Source: QResearch,
database version 16
QResearch © 2008*

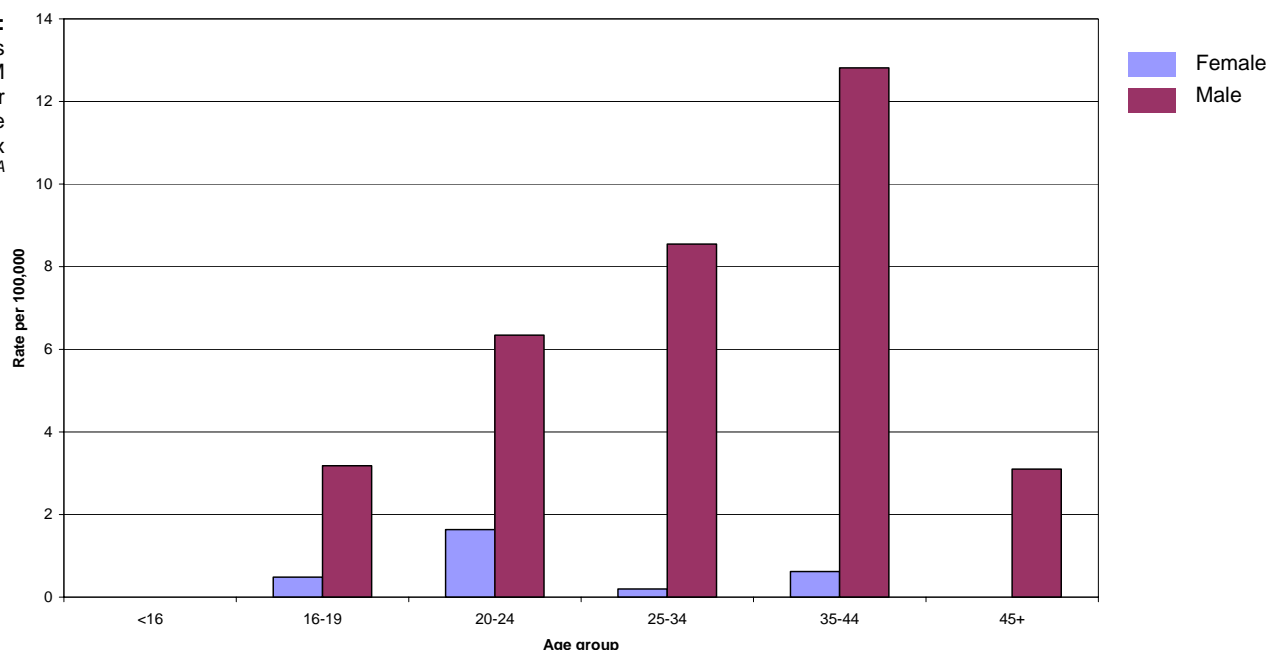


* General practice rates have been suppressed when the rate was calculated from fewer than five patients

Syphilis

Syphilis has re-emerged in the UK since the mid 1990s, and the rates of syphilis diagnosed in GUM are shown in figure 24. Diagnosis rates are considerably higher in males with the highest rates of diagnoses of over 8 per 100,000 population in the 35-44 age group. A majority of syphilis cases are diagnosed in MSM⁵. In order to inform syphilis control activity, a nationally enhanced surveillance system collects detailed data on cases diagnosed in GUM. Rates of syphilis managed within General Practice are known to be negligible⁶

Figure 24:
Rate of Syphilis
diagnosis in GUM
clinics in 2006 per
100,000 by age
group and sex
Source: HPA



Lymphogranuloma Venereum

Of the 539 individuals diagnosed with lymphogranuloma venereum (LGV) in England 56 have been in the South East. All cases were in males and 98% were known to be MSM. Table 1 shows the delay in diagnosis and the presence or absence of symptoms. Table 2 shows the HIV status of the individuals diagnosed with LGV.

Table 1: Delay in LGV diagnosis in the South East by presence and absence of symptoms.

Length of delay	Symptoms		Total
	Yes	No	
no delay	1	1	2
up to 1 month	30	2	32
up to 2 months	5	0	5
up to 3 months	0	0	0
more than 3 months	12	4	16
Missing data	0	1	1
Total	48	8	56

Table 2: HIV status of individuals diagnosed with LGV.

HIV status	Number
Positive	42
Negative	13
Unknown	1
Total	56

Pelvic inflammatory disease and ectopic pregnancy

Pelvic inflammatory disease (PID) is a general term for infection of the uterus (womb), fallopian tubes and other female reproductive organs. It is a common and serious complication of some STIs, especially Chlamydia and Gonorrhoea. Untreated PID can lead to long-term health problems including infertility, ectopic pregnancy and chronic pelvic pain.

A variable proportion of cases of PID are admitted to hospital, and these are generally women with more severe disease. Ectopic pregnancy, by contrast, is wholly managed in secondary care and should therefore be well ascertained in Hospital Episode Statistics.

Figures 25 and 26 show the variation in incidence of hospitalized PID and ectopic pregnancies among local authorities in the South East region, shown grouped into Strategic Health Authority (SHA) areas. The local authorities with the highest incidence are in South Central SHA, but the width of the confidence intervals mean that no real difference can be perceived between the two SHAs. There is statistically significant variation, however, *within* each SHA: in each case the highest rates are significantly greater than the lowest rates, demonstrated by confidence intervals which do not overlap. The pattern is broadly similar for ectopic pregnancies, although local authorities with high rates of PID do not all have high rates of ectopic pregnancy, and vice versa. There is also less marked variation between rates of ectopic pregnancy in different local authorities.

Studying data on PID illustrates again the difficulties inherent in surveillance and monitoring of STIs. The data shown here relate to hospital admissions for PID, but many cases of PID are diagnosed and treated by general practitioners, and some women are also managed in GUM clinics. The relative accessibility of these settings and the lack of primary care data make it difficult to estimate the burden of disease accurately.

Please note PID data presented in this report is based on hospital episodes unlike in the previous year's report which was based on hospital admissions for a primary diagnosis of PID. This has resulted in the numbers increasing considerably because of the number of individuals diagnosed with PID after being admitted for a different reason (e.g. someone admitted with appendicitis and subsequently transferred to gynaecology for PID).

Figure 25:
Episodes of pelvic
inflammatory
disease (ICD10
N70-N74)
Directly
standardised rates
and 95%
confidence
intervals
2004/2005 to
2006/2007,
pooled, all ages
*Source: Hospital
Episode Statistics, NHS
Health and Social Care
Information Centre*

Local Authority

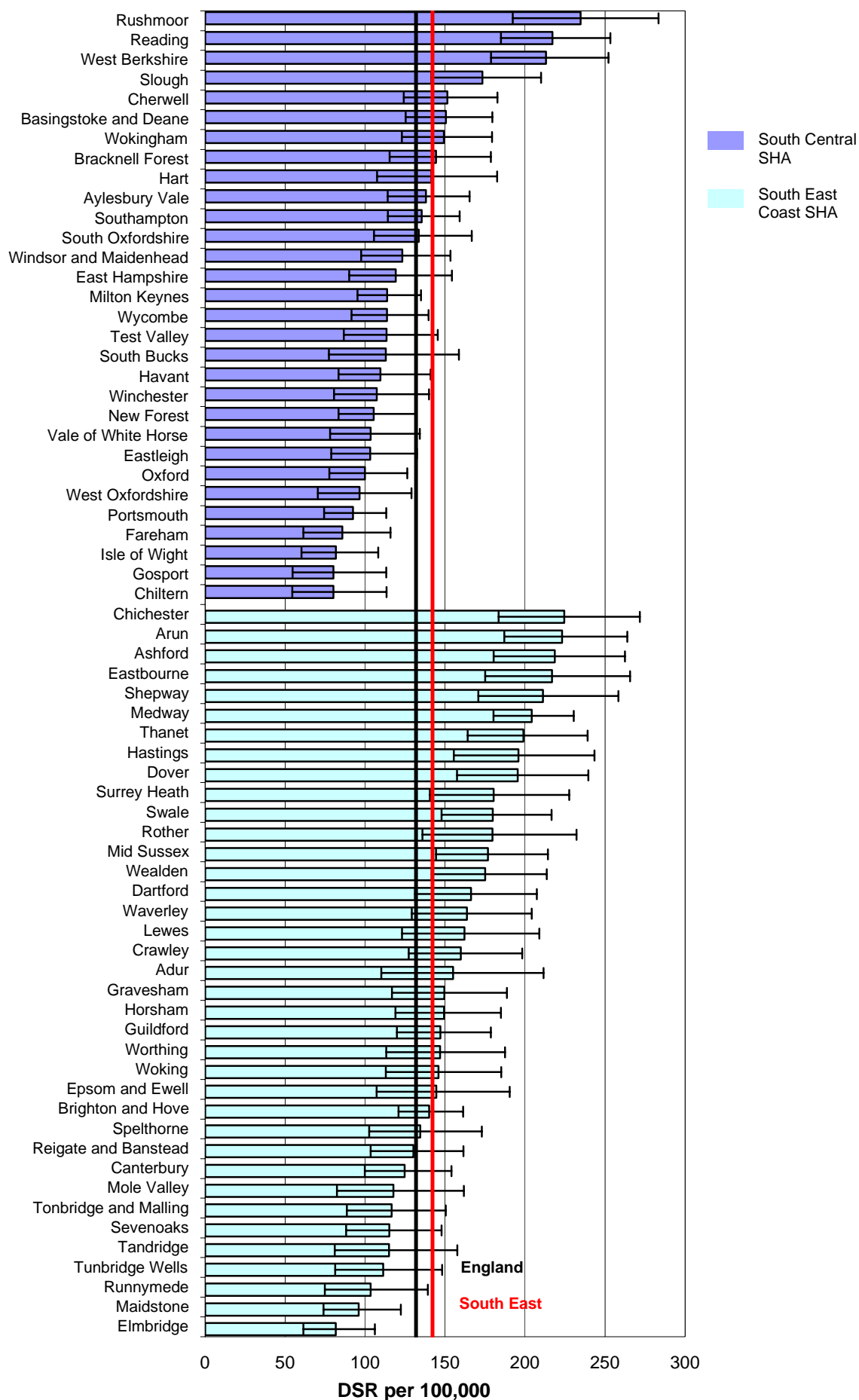
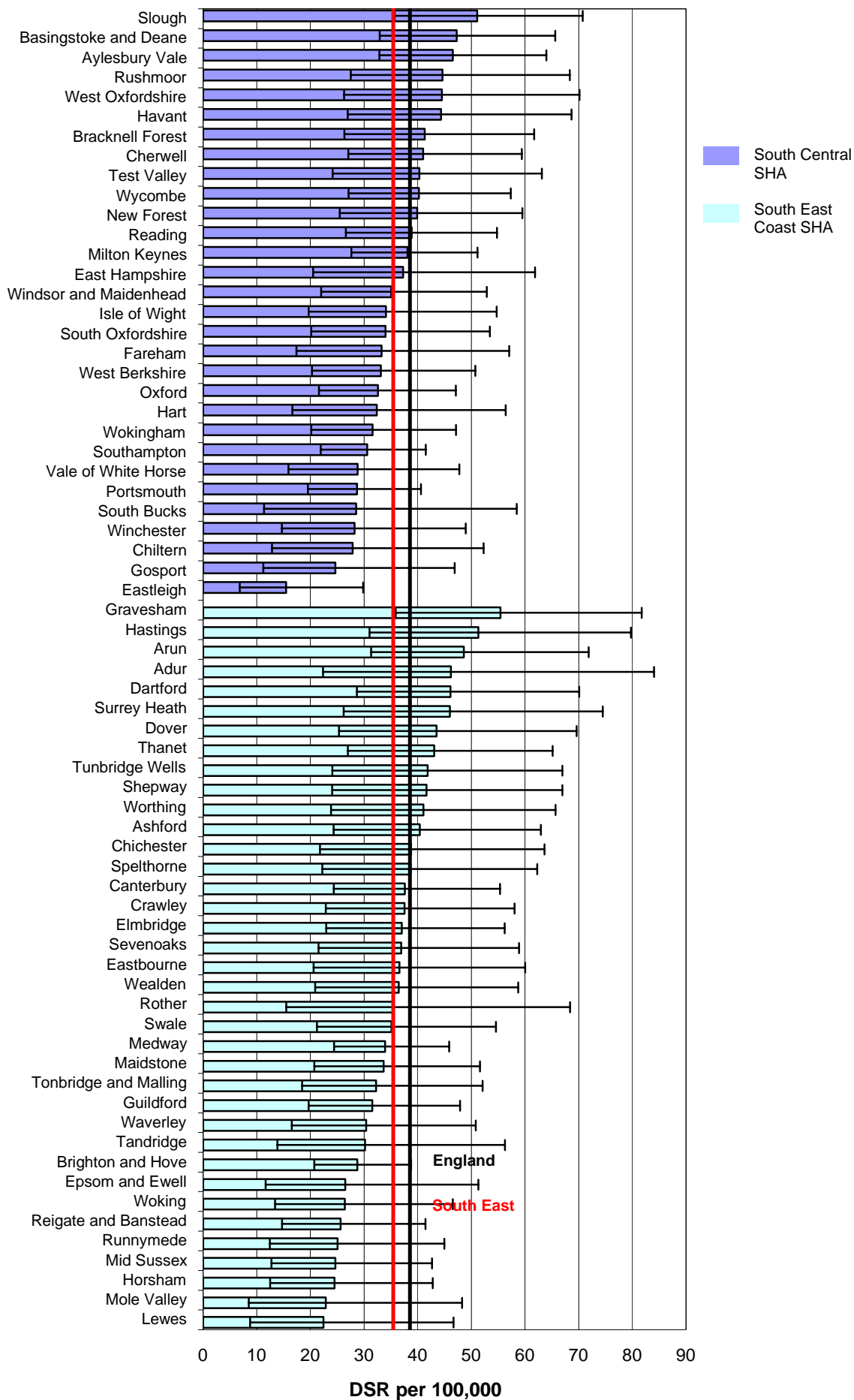


Figure 26:
Episodes of ectopic pregnancies (ICD10 O00)
Directly standardised rates and 95% confidence intervals
2004/2005 to 2006/2007, pooled, all ages
Source: Hospital Episode Statistics, NHS Health and Social Care Information Centre

Local Authority

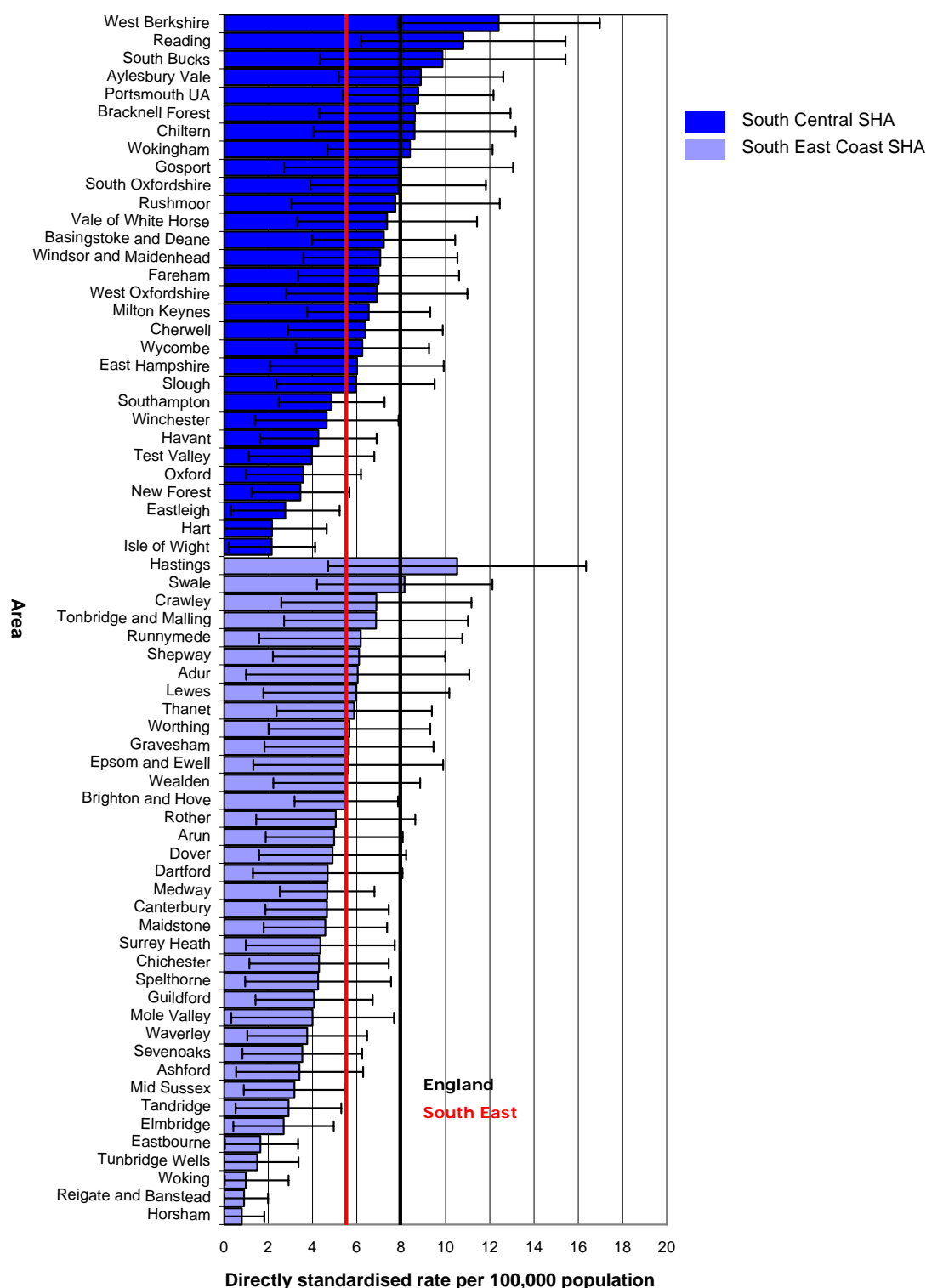


3.5. Cervical Cancer

Vaccination against the major genital carcinogenic subtypes of the human papilloma virus is about to begin among adolescent girls. This will present new challenges for assessing the effectiveness both of the vaccination programme, and of the cervical screening programme which looks for precancerous changes in the cervix.

Figure 27 shows the incidence of cervical cancer among women in each local authority in the South East region. Reading and West Berkshire have rates significantly above the regional average whilst eleven local authorities have rates below the regional average including the Isle of Wight and Horsham which have the lowest rates in South Central and South East Coast respectively.

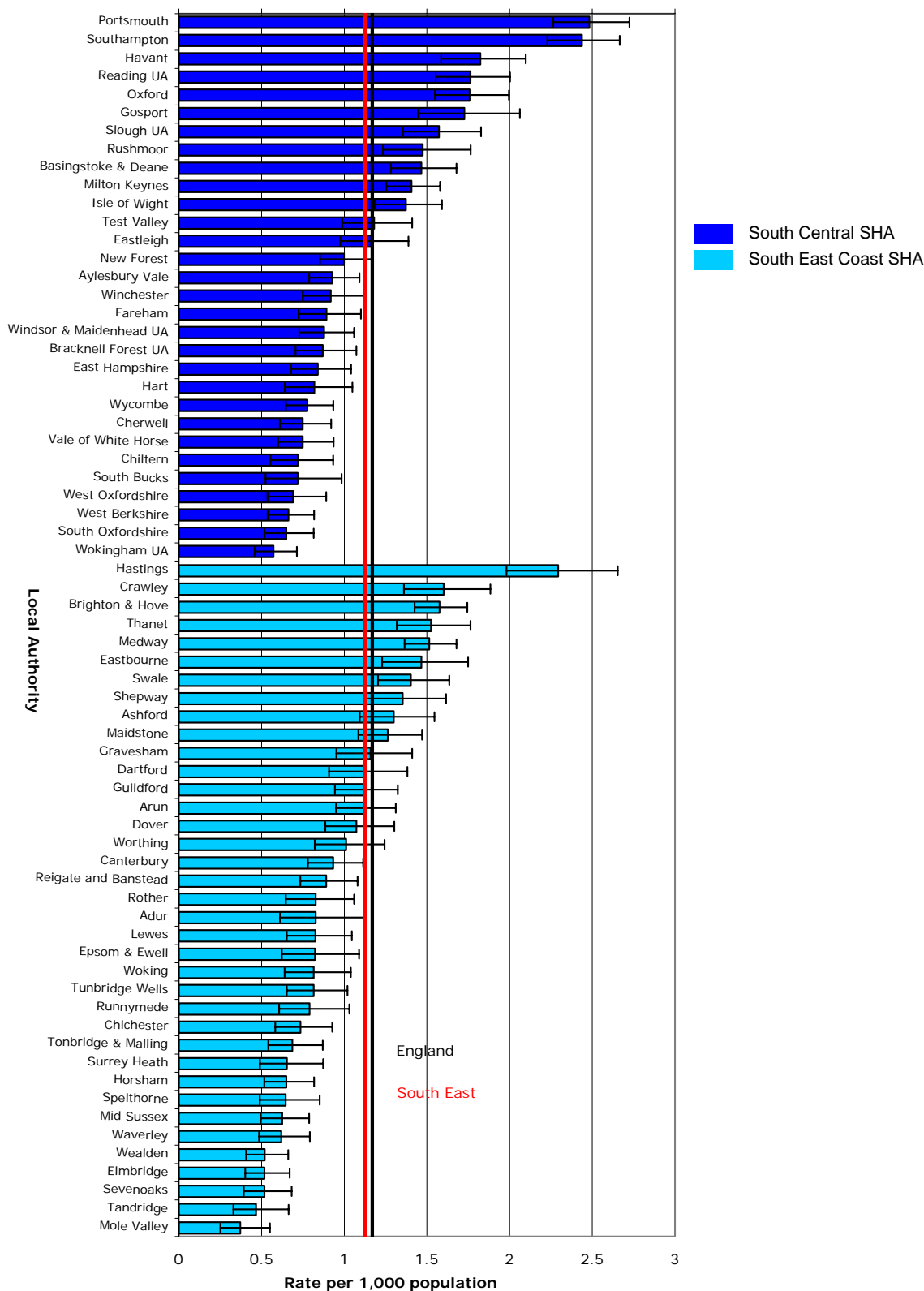
Figure 27:
Directly standardised
rate of cervical
cancer incidence
among women in the
South East 2003-
2005
Source: Southern Cancer
Information Service



3.6. Sexual Violence

Figure 28 summarises data on sexual violence across the South East, using data from the British Crime Survey.

Figure 28:
Sex offences: crude
rate per 1,000
population; local
authorities in the
South East.
Recorded crime and
British Crime Survey
Comparator
2005/2006
Source: Home Office



3.7. Blood borne viruses other than HIV

Sexual transmission is an important mode of transmission for Hepatitis B, and in MSM there is increasing evidence of sexual transmission of Hepatitis C through this route⁵.

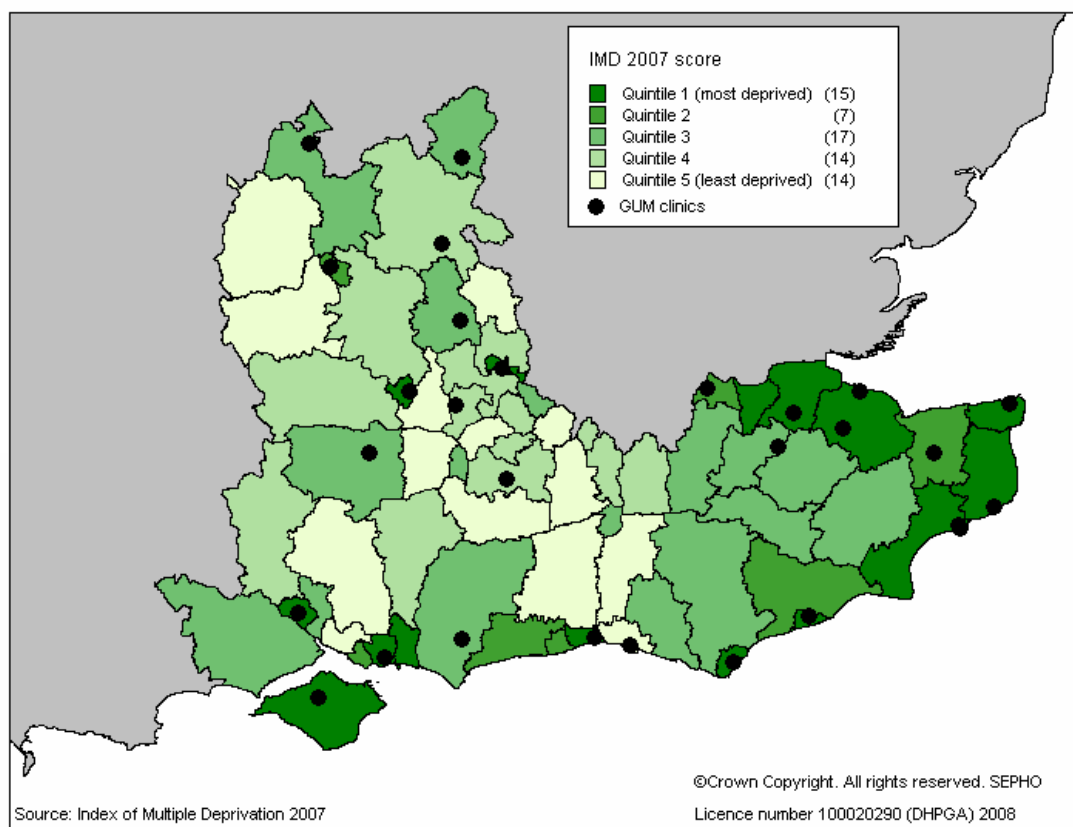
4. Improving sexual health in the South East

4.1. Sexual Health services in the South East

Figure 29 shows the distribution of genitourinary medicine clinics across the South East. We were not able to provide a similar map for contraceptive services, but hope to do so next year. These maps demonstrate the variation in access to local sexual health specialist services across our region, which includes both rural and dense urban populations. Improved data for sexual health activity in primary care is essential for the equitable monitoring of services – in the case of STIs, primary care diagnoses are in effect “invisible” to current routine surveillance.

KT31 data, published by the Department of Health, allow comparison of contraceptive clinic attendances at PCT level and with data for England. Inequalities are likely to be important in the prevention of unwanted pregnancy. There is evidence that availability of contraceptive clinics increases usage of the highly reversible long-acting methods of contraception, and that these are currently under-available to women, particularly those who only have access to general practice contraceptive services¹¹.

Figure 29:
Index of multiple
deprivation scores
and location of
GUM clinics,
South East region
2006

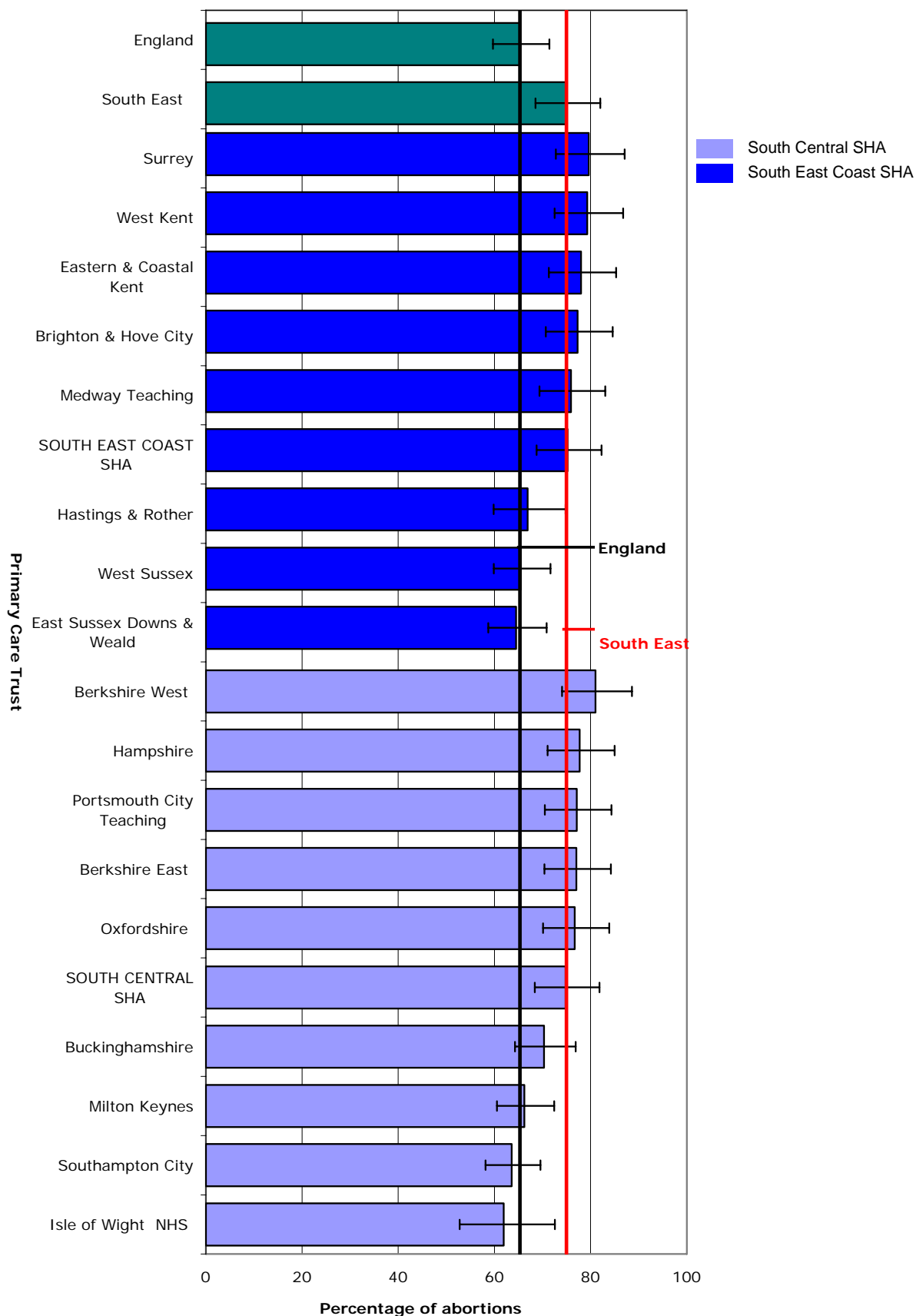


Abortion services in the South East

Comparative data on the percentage of all abortions which took place before 10 weeks gestation are shown in Figure 30.

Figure 30:
Percentage of
NHS funded
abortions which
took place before
the 10 week stage
in the South East,
2006

Source: Department of
Health

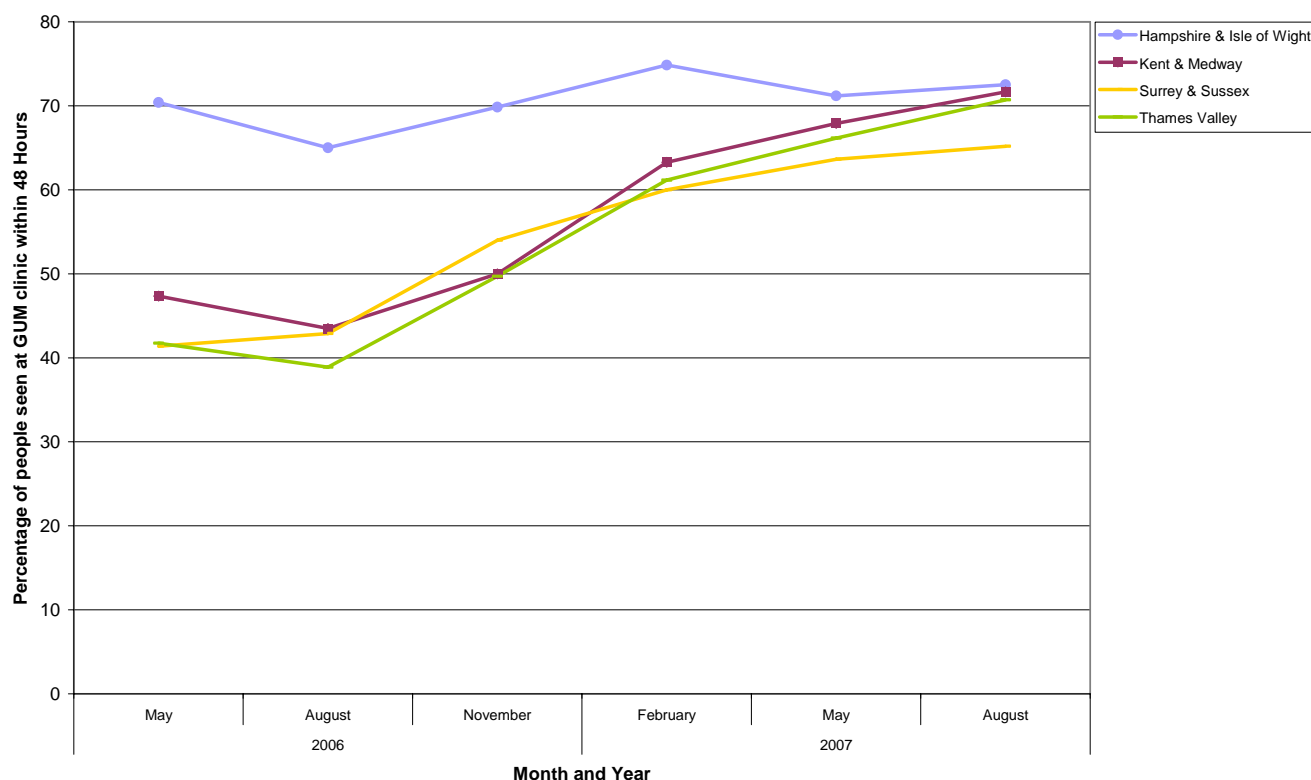


Waiting times for genito-urinary medicine (GUM) clinics

The HPA has been collating waiting times statistics for patients attending genitourinary medicine (GUM) clinics since 2004. These statistics show the proportion of patients that are seen at GUM clinics within 48 hours, which is a key NHS priority.

Figure 31 shows the average proportion of people seen within 48 hours at GUM clinics by HPU of residence over the past 18 months. Surrey and Sussex, Thames Valley and Kent have improved over this time to between 65 – 72% becoming comparable to Hampshire and the Isle of Wight who have been relatively consistent over this time. August 2007 was the last survey of this kind and monitoring of GUM waiting times will now be conducted through the Department of Health.

Figure 31:
Percentage of people seen at GUM clinics within 48 hours by HPU by month from May 2006 to August 2007
Source: HPA



New surveillance systems

The Department of Health's new system to monitor GUM clinics is GUM access monthly monitoring (GUMAMM). This system has been approved by the Information Standards Board (ISB) and is likely to result in the system becoming mandatory for providers by October 2008 (subject to ISB mandate).

The monitoring of STIs in GUM clinics through KC60 surveillance is will also be superseded later this year. The new system is GUM clinic activity data (GUMCAD). This system will collect residence based data using slightly revised KC60 codes. The system will run in parallel to the current KC60 surveillance for approximately six months to validate the new system.

Primary care surveillance

STIs are increasingly being diagnosed in primary care (Cassell, 2006). Currently surveillance within primary care occurs through a sentinel surveillance system, Qresearch, and therefore only measures a sample of general practices throughout the country. There is also high variation of STI diagnoses and treatment within general practices and therefore sentinel surveillance systems may not be sufficient to assess the burden of STIs diagnosed and treated outside the GUM clinic services.

In 2006 the Royal College of General Practitioners (RCGP) and British Association of Sexual Health and HIV (BASHH) recognised the increasing diagnoses of STIs in General Practice and joined together to produce management guidelines for GPs. The document 'Sexually Transmitted Infections in Primary Care' can be downloaded from the following website:

http://www.rcgp.org.uk/PDF/clinspec_STI_in_primary_care_NLazaro.pdf

This in some way supports the need for improved surveillance of STIs in primary care to determine the overall burden of disease presenting within the primary care setting.

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